

PSYCHIATRY

The Treatment of Psychosomatic Syndromes in General Practice*

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The general practitioner is constantly faced with problems that require psychiatric understanding¹, and it has always been accepted that some physicians are eminently successful because of their human understanding and because they can utilize this understanding to promote recovery of their patients². We also recognize the fact that the general practitioner in the small community, who knows the background, family, and acquaintances of his patient, often intuitively or consciously utilizes this knowledge in helping him to make a diagnosis or to outline treatment. The ability to utilize such knowledge and understanding of the patient's personality and background has been considered as a more or less intangible asset of the individual physician and has been put under the heading of the art of medicine³. In many communities, it is the general physician who must recognize and manage the majority of psychologic problems, and in almost any community, he is usually the first to see the patient whose emotional conflicts have led to the development of anxiety and physical distress¹⁵.

It is important to realize that the diagnosis either of emotional or of psychosomatic illness does not mean that referral to a specialist is inevitable. There are many problems of a minor nature which the general practitioner can and should treat. Deuker⁴ concluded, from a survey of 500 disability insurance claims for psychoneurosis treated with superficial therapy by the general practitioner, that the duration of disability and percentage of improvement showed "no significant difference in the therapeutic success obtained by practitioners, psychiatrists, or psychoanalysts" and that "the common sense and judgment required in intelligent treatment of this condition can be affectively provided by the capable general practitioner as by the psychiatrist."

Stanfield¹⁶ discusses the possible criteria which a general physician might use in deciding for or against referral of his patient to a psychiatrist,

and suggests that consideration be given to three main areas:

Diagnosis—Patients should be referred if they represent cases of acute or chronic psychoses, severe or chronic psychoneuroses. However, the general practitioner has definite advantages in the management of patients with mild anxiety symptoms, certain of the psychosomatic disorders (for example, peptic ulcer, essential hypertension, and mucous colitis), and patients reacting to adverse changes in their life situations.

Severity—"Generally speaking, the more severe the personality distortion and functional disability, the more pressing is the demand for intensive treatment. The hazard of self-injury or impulsive action increases (within limits) with severity, as does the risk of personality rut-formation, hopelessness, regression, social and therapeutic exile."

Prognosis—"Patients with only fair or doubtful prognosis, or good prognosis with intensive psychotherapy, are best handled by referral for specialized treatment." A review of the following factors can be of some assistance in prognosis—within considerable margin of error:

History of Past Performance

Favorable:

(a) Average or better school work, social, and marital adjustments preceding the onset of the illness.

(b) Consistency in effort, goals, standards—but not to the extent of rigidity or perfectionism.

(c) Failures and illnesses only in relation to severe stress.

Unfavorable:

(a) Early and/or repeated emotional illnesses during life, in response to minimal or average stress.

(b) "Neuropathic traits in childhood, especially if sustained; evidence of developmental anxiety during formative years (for example, enuresis, excessive nailbiting, tantrums, phobias).

(c) Impulsivity in school, work, social behavior.

(d) Insidiously developing psychopathology.

Current Personality Factors

Favorable:

(a) Evidence of basic maturity, revealed in such factors as listed by Levine⁹: (1) ability to be guided by reality rather than by fears; (2) use of long-term values; (3) grown-up conscience; (4) independence; (5) capacity to love someone else, but with an enlightened self-interest; (6) a reasonable dependence; (7) a reasonable aggressiveness; (8)

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healthy defence-mechanisms; (9) good sexual adjustment with acceptance of own gender; (10) good work adjustment.

(b) Strong therapeutic motivation (anxiety, aggressiveness, future goals).

(c) Rapport with physician.

(d) Insight (acceptance, at least, of psychologic mechanisms related to symptoms).

(e) Average or better intelligence.

(f) Broad fund of experience and interest.

Unfavorable:

(a) Marked immaturity.

(b) Apathy, indifference to illness, self-centeredness.

(c) Delusional content; unrealistic and autistic thinking.

(d) Preoccupation with organic symptoms.

(e) Narrowed intelligence, interest, and experience.

(f) Evidence of "neuropathic" traits (nailbiting, tics, stuttering, etc.).

(g) Incongruous affect or unaffected biologic rhythms in contrast to severe symptomatology.

Situational Factors

Prognosis proportionate to:

1. Capacity for insight or modification on part of relatives, associates.

2. Alterability of anxiety-producing stress and dissatisfactions (economic, interpersonal, etc.)¹⁶.

It has been observed time and time again that even when the general physician is aware of the presence of emotional factors in the patient's illness, there is often a tendency to avoid the making of the diagnosis of an emotional disorder. Yet, it has been generally estimated that from 30 to 50 per cent of all persons seeking medical advice, are suffering from functional disorders. Furthermore, with the increasing number of older persons in our society, the importance of emotional factors becomes even greater, for the process of aging itself brings to the fore the patient's personal limitations and idiosyncrasies, and chronic illness commonly imposes some re-adjustment to life¹⁸. In spite of this, many physicians are interested in a functional disorder only as long as it remains a diagnostic problem—an attitude which is probably carried over from the great emphasis placed on differential diagnosis in our medical education. Moreover, there has been a change in the relationship between the family physician and the patient. Less often nowadays, does the physician know the family background, the circumstances, past life, home situation, and other vital facts about his cases through contact with them as human beings. And rarely in his busy office practice, does he want to take the time needed to acquire an adequate picture of the patient's personal background. Every-

one rationalizes his lack of knowledge and understanding, his failures and his successes. Thus, both the patient and the physician constantly tend to rationalize the patient's complaints and avoid the acknowledgment of an emotional disorder. It is well to remember that one's inability to see psychic etiology does not necessarily indicate its absence¹⁴. Too often has over-examination calcified neurotic symptoms and too frequently does the physician fail to recognize psychiatric implications and, in spite of negative findings, treat the patient "as if" there were an organic disease. Small¹⁵ points out that the rationale for this is based on the assumption that the patient needs to feel there is something physically wrong with him. Such an attitude of misguided over-solicitude often causes the doctor to say to his patient "There is nothing wrong with you" when the patient has obvious alterations in function or distressing complaints¹⁵. How much more profitable for both doctor and patient would be a discussion of common examples of the inter-relationship between bodily functioning, the autonomic nervous system, and various emotional states.

As competent and thorough general practitioners, we must become interested in the personality structure of our patient, make routine inquiry into emotional factors in history taking, and consider the relationship of symptom to conflict. Emotional illness is not diagnosed by the exclusion of organic disease, but by the following positive clinical data:

1. The presence of a multiplicity of complaints, which are frequently of a shifting, changeable nature and which often involve several body systems simultaneously.

2. A past history of illnesses or complaints that have been chronologically correlated with periods of stress, and that have responded favorably to psychotherapy or mild sedation, and that have been alleviated or increased, depending on the change in the social situation. Also important in the past history is the presence of a prolonged illness or prolonged convalescence, especially if precipitated by accident or operation and associated with emotional conflict. Treatment of the same complaint by a great many physicians is likewise of interest. Symptoms or complaints out of proportion to the somatic factors, or about which the patient expresses undue concern, are also indicative of emotional disorder.

3. The presence of important conflicts or mal-adjustments, and the degree of insight of the patient concerning these factors. This is evaluated in terms of the patient's general personality structure and development. The same conflict will differ in its effects on the personality depending on whether it occurred in the first five years of

life, in the pre-puberty, in adolescence, or in adulthood. The complaints are then evaluated in terms of their possible relationship to the underlying conflicts.

4. The existence of an unfavorable early home environment and the development of neurotic traits in childhood. This includes also the exposure of the patient in childhood to disease experienced by the parent, relative, or others in close relation to him. Instability of the parents, insecurity, rejection, hostility—all these influence the emotional life of the child, and determine to some degree, his later adult adjustments and satisfactions.

In seeking to help people, our first interest is in the relationship between the patient's personality and his illness. Symptoms are often attempts to solve problems, and we must discover and treat the conflict causing the problem, not merely the complaints. Any illness is a total life situation which disturbs the normal equilibrium that we maintain in our adjustments. The multiple factors of the patient's previous experiences, his personality structure, his personality needs, the immediate situation—all play a role in motivating the patient who comes for treatment. It becomes an important matter of therapy to evaluate the patient's attitudes toward his illness. Any illness usually results in a state of unaccustomed dependency which may be resisted or may be welcomed by the patient. The goal of the physician is to understand the patient's attitudes and personality trends in order to decide if they act to perpetuate his maladjusted state of functioning. Does he welcome his invalidism? Or does he fear the illness, the hospital, the separation from his environment? How are his responsibilities—personal, economic, and social—affected by the illness? Such personality trends must be recognized and taken into account, for the patient's illness may represent a defense mechanism for handling anxiety at the price of moderate distress or disability.

Since it is in the realms of sentiments and prejudices, in the attitudes towards parents, home, church, work and other people that the patient will most clearly reveal his significant personal feelings, the physician must counteract his natural tendency to condemn all behavior that conflicts with his own standards. If we impute to the patient our own feelings, we will often seriously misunderstand the patient's problems and his response to them. If we pass judgement on the patient's attitudes, we forget our final goal of understanding the causes of behavior and of illness and helping people in accord with our own and the patient's ability.

Having considered these background factors, we shall now concern ourselves with the process of treatment itself. Usually, the patient begins with his physical complaints and the physician should encourage the patient to talk by asking such non-leading questions as "How can I help you?" or "What can I do for you?" or "How has everything been going?" It is important to let the patient talk and to record the presenting complaint verbatim¹⁰, because the way in which he gives his original complaint often reveals his attitudes toward it. Letting the patient talk gives you the advantage of seeing the problem from the patient's point of view. The good physician is a good listener who notices tension, flushes, facial expressions, gestures—anything which reveals the feeling behind what the patient is saying¹⁷. When he finishes his initial complaint, the question "What else troubles you?" is usually sufficient to bring out more symptoms. This is continued until the patient finally responds "That's all¹⁰." In this manner, the doctor can learn what the patient feels are his problems, and thus, the physician avoids rushing ahead before understanding the whole problem.

At this point, it is usual to hear about the "present illness," its development from the time the trouble began. If this is again a spontaneous statement, the doctor can learn about the patient himself as well as his illness. Whitehorn¹⁰ advises the physician to consider the manner in which the patient recounts his symptoms, whether he is interested or indifferent, whether he dramatizes his complaints, dwells on them for sympathy, comes with a piece of paper on which are detailed notes, or indulges in hair-splitting qualifications or arguments. The physician thus assumes the role of an observer, as well as a participant in the interview—a dual role which may sometimes be difficult, but which is always necessary to good interviewing. If the patient is not hampered by the doctor, the "history of the present illness" affords him an opportunity to discuss the troublesome life situations to which his sickness is related¹⁹.

When a feeling of mutual understanding has developed from the informal and spontaneous interviewing, the physician can fill in gaps in the history by questioning the patient regarding pertinent data in his life. It is important for the patient to realize that the doctor is asking questions in order to be of assistance and to understand the patient better. The manner of the physician, his tone of voice, his awareness of the patient as a person, all help to assure the patient that the doctor is interested in him as a sick individual and not as a disease syndrome. At this time, the doctor can obtain through his "system review" any information not fully given in the

spontaneous complaint. Thus, a good medical history can be obtained without fear of suggesting new symptoms or blocking the expression of present ones. It is only through full and free discussion that the patient and the doctor can ever evaluate properly the roles of the functional or organic factors.

The general practitioner often feels that this procedure is too time-consuming, but to allow a patient to give a spontaneous complaint on the first visit saves an immeasurable amount of time later on. When a patient in later visits begins to repeat his complaints, he can be politely told that this has already been discussed and is being considered. Moreover, any supposedly time-saving method that results in a wrong diagnosis is not time-saving, either to the patient or to the doctor¹⁰.

The physical examination which is usually done at this point in the case should be carefully combined with further questions and can be good psychotherapy. It must be thorough enough to convince both the patient and the doctor that he knows whereof he speaks. If special laboratory work is indicated, it is done at this time. The entire examination must be complete enough that the doctor will not have to keep repeating it for his own and the patient's reassurance.

With the completion of these initial interviews and the physical and laboratory examinations, a preliminary formulation of the case is in order. This gives the physician an opportunity to explain his diagnosis to the patient and to offer the patient the opportunity to plan for treatment. If the complaints are on an emotional basis, the physician discusses with the patient the absence of organic disease, points out that there is no question about the validity of his complaints but only that their cause lies in the emotions, and then gives illustrations of the relationship between emotion and bodily symptoms. If the patient resents the suggestion that his illness is on an emotional basis, this is best handled by an inquiry to determine why this factor is upsetting to him. The doctor should stress that the patient's complaints represent the response of a normal body to abnormal situations or to conflicts and problems, and that there is a logical explanation for his complaints.

From this point, the continuing process of therapy centres around the use of the doctor-patient relationship as an example of the nature of the interpersonal relationships between the patient and other persons. The aim of treatment is not to solve one particular problem, but to assist the patient to grow so that he can cope with the present problem and with later problems in a better integrated fashion¹¹. This requires a fur-

ther clarification of the patient's reasons for coming to treatment. It never can be taken for granted that the patient wants help with all of his problems; certain types of neurotic adaptation are entirely satisfactory until unusual stress occurs².

Coleman² states that few patients have any understanding of the nature of treatment when it concerns an emotional disorder. Following the pattern of general medical practice, the patient has presented his complaints and his problems and he now expects a program of active handling of these complaints; he waits for advice, explanation, reassurance, interpretation, or, at least, a prescription. Unconsciously, the patient also wants understanding and gratification and seeks to avoid frustration of his emotional needs. By a constant inspection and analysis of the reaction between physician and patient, the doctor can see how the patient allows his anxieties to emerge and how capable he is of handling this anxiety. In order to relieve anxiety, the patient must feel that the doctor understands and accepts him as a person. When the therapist is viewed by the patient as a reliable and trustworthy parent-figure, then the patient can utilize his trust in the doctor for progressive exposure of his anxiety and can become increasingly tolerant of it².

The general framework for useful doctor-patient relationship includes the following:

1. A regular appointment schedule with scrupulous respect to the patient's right to the time agreed upon. For the great majority of patients, a once-a-week schedule is satisfactory, with an increase in frequency at any time the patient develops an acute emotional reaction, which he might not be able to carry over a week without distress².

2. Helping the patient to assume as much responsibility as possible for himself and for the working through of his problems. The patients acquire the certainty that no demands will be made on him that he cannot handle or that will call forth unmanageable anxiety².

3. Continual focus of the needs and the person of the patient! When, in the course of his interview with the patient, the doctor has made some comment, he must be constantly inquiring of himself: What purpose did it serve? Did the therapist know what the patient was trying to say, or what feelings he was trying to express? How did the therapist feel about the patient and the patient's remarks at the time he threw in his own comment?

Thus, there is a progressive development of the therapy situation so that the needs and problems of the patient are recognized, identified, worked through, and allowed to find resolution within the physician-patient relationship².

After the need for treatment is understood by both the patient and the physician, the doctor places no restriction on the content of the material which the patient chooses to discuss. He is free to bring out his feelings, and particularly his anxieties, about whatever problems are of concern to him. The expression of feeling is encouraged by the doctor's interested, receptive, objective, non-critical attitude and by his recognition of the feeling-tone which underlies the intellectual content which the patient expresses. Treatment thus becomes the patient's opportunity and responsibility. If the patient can bring out his hostilities, his anxieties, his concerns, his ambivalences, and his feelings of guilt—and have them accepted without criticism by the doctor—then the patient can recognize these feelings in himself and accept them as part of himself. He has an opportunity to understand himself as he is. The physician's role is to understand what the patient is trying to say, what feelings he is trying to express, and help the patient to identify them. The doctor usually can do this adequately until the patient expresses either hostility or positive feelings toward the doctor. Such feelings will develop inevitably and the physician wants not to eliminate them, but rather to direct their nature and intensity¹⁸.

This viewpoint of therapy means a freedom for the patient from any type of pressure, or advice, or decisions from the physician. It demands self-restraint on the part of the doctor, a willingness to avoid imposing his own judgments on the patient, and an acceptance of the existence of a desire to get well on the part of all patients. When the patient can see for himself old facts in their new light, when he has a better understanding and acceptance of himself and his feelings as a normal part of himself, when he can choose satisfying goals in reality, then treatment has been successful and the time for terminating has arrived. Treatment often is unnecessarily prolonged because the physician unconsciously holds on to the patient. When the patient recognizes that he is handling problems with increasing assurance, he is free to end the treatment relationship and also free to come again if he needs future help.

Appel¹, discussing dynamic growth therapy, expresses an attitude regarding therapy which will well serve to close this paper; he states it "is a growth experience in which the patient feels and learns. This growth takes place within a relationship between two human beings, an effective relationship which is of greatest importance in

therapy. There is release of repressed clogging and disrupting emotions, through the expression, recognition and acceptance of the patient's feelings. It is recognized that the way he feels is more fundamental than what he thinks. Therapy is not, therefore, just a process of discovery, recognition, decision, and automatic implementation of new ideas and formulae for satisfactory living. It is a slow, groping process which, in addition to intellect involves feeling, and furthermore action—trial and error in the practice of living. Since most growth takes place unconsciously, the process of therapy takes time. The forces of imagination and identification are recognized as more important in many people than reason and will-power. The patient must learn to grow out of his hindering identifications and work through to a new individualization in order to achieve a satisfying and constructive personality."

Bibliography

1. Appel, K. E.: Psychiatric Therapy, Chapter in Personality and the Behavior Disorders. Edited by J. McV. Hunt, p. 1107, the Ronald Press Company, New York, 1944.
2. Colman, J. V.: The Patient-Physician Relationship in Psychotherapy. *Amer. J. Psychiat.*, 104, p. 638, April, 1948.
3. Daniels, G. E.: "The Psychosomatic Approach in Medical Practice." Invitational Lecture given at Colorado Psychopathic Hospital, May, 1948.
4. Dinker, P. G.: Results of Treatment of Psychoneuroses by the General Practitioner, *N.Y. St. J. Med.*, 46, p. 2164, 1946.
5. Ebaugh, F. G.: Need for Improvement in Medical and Psychiatric Concepts. *Rocky Mt. Med. J.*, 42, p. 352, May, 1945.
6. Ebaugh, F. G.: Evaluation of Interviewing Technics and Principles of Psychotherapy for the General Practitioner. *J. Omaha Mid-West Clin. Soc.*, 9, p. 1, January, 1948.
7. Garrett, A.: Interviewing, Its Principles and Methods. Family Welfare Assoc. of Amer., New York, 1942.
8. Harrison, F. M.: Biological Concepts in Psychiatry. *U.S. Nav. Med. Bull.*, 40, p. 308, April, 1942.
9. Levine, M.: Psychotherapy in Medical Practice. Macmillan, New York, 1942.
10. Lyon, J. M.: Interviewing Technics. *Amer. Pract.*, 1, p. 174, December, 1946.
11. Malamud, W.: Brief Psychotherapy in Medical Practice. *Med. Clin. N. Amer.*, 32, p. 1195, September, 1948.
12. Rennie, T. A. C.: Anxiety States: Their Recognition and Management. *Med. Clin. N. Amer.*, 32, p. 597, May, 1948.
13. Rogers, C. R.: Counselling and Psychotherapy. Houghton Mifflin Company, Boston, 1942.
14. Schiele, B. C.: Psychosomatic Medicine and Psychiatry. *Dis. Nerv. System*, 7, p. 101, April, 1946.
15. Small, S. M.: Psychotherapeutic Orientation for the General Practitioner. *Med. Clin. N. Amer.*, 32, p. 695, May, 1948.
16. Stanfield, C. E.: Psychotherapy: An Orientation for Non-Psychiatrists. *Amer. J. Med. Sc.*, 216, p. 97, July, 1948.
17. Weiss, E., and English, O. S.: Psychosomatic Medicine. W. B. Saunders Company, Philadelphia, 1943.
18. Whitehorn, J. C.: Psychiatry as a Basic Medical Science. *Conn. Med. J.*, 6, p. 693, September, 1942.
19. Whitehorn, J. C.: Doctor's Evaluation of Patient's Attitudes. *Med. Ann. Dist. of Columbia*, 12, p. 213, June, 1943.
20. Whitehorn, J. C.: Guide to Interviewing and Clinical Personality Study. *Arch. Neurol. and Psychiat.*, 52, p. 197, September, 1944.

SURGERY

Basic Principles of Traumatic Shock

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In the evolution of the human organism from his lowly origin to this age of jet propulsion, civilization has created many problems for those of us who seek to prevent mankind from self-destruction. This is the day of bigger and better accidents, bigger and better guns and bombs. As a consequence, traumatic shock and its treatment, occupies a more and more important place in the everyday practice of the doctor. Periodic reviews of this important subject, therefore, should be of interest.

In the past, the theoretical aspects of traumatic shock have been clouded with mystery and dissension. This is still so at the present time. Fortunately, for those of us who have to deal with this condition, the clinical approach is relatively simple. We know that in shock there is a tremendous fluid loss. We know that this fluid loss unless corrected will lead to a definite chain of events which will result in the death of the patient. Just why vascular capillaries should suddenly become as leaky as an old boot as result of trauma is of academic interest only, and the many explanatory theories have no place in a paper of this length.

Clinically we recognize two types of traumatic shock. The neurogenic type (or so-called primary shock) is a reflex phenomena, due to pain and fright. It causes the vascular bed to relax, lose its tone and increase in its total capacity. There is a relative reduction of the total blood volume only, with consequent fall in the blood pressure with right ventricular failure and peripheral vascular failure. All this leads to cell anoxia and death of the patient. It occurs immediately following the accident and by the time the physician sees the patient, the primary or neurogenic shock has either corrected itself or merged into secondary shock. The treatment for this condition is the same as secondary shock, except that, if seen in its early stages, morphine is of the utmost importance to relieve pain.

Secondary shock is due to an actual loss of fluid from the vascular field. If caused by an actual tear in the vascular continuity with resulting hemorrhage and loss of whole blood from the circulation, it should be treated as far as possible by the injection of whole blood. When this is not possible the treatment is the same as that used when blood volume is reduced by simple capillary leakage.

The form of secondary shock most frequently encountered from trauma (including burn trauma)

follows a definite sequence of events. Trauma is applied to the body. In some indefinable manner the vascular capillaries are rendered pervious to the passage of the colloid, serum protein. This causes intravascular colloid to pass to the interstitial spaces and to accumulate in a great pool. The high colloid content of the interstitial spaces attract great quantities of water and sodium chloride from the blood stream. The total blood volume is thus reduced. The reduction of the total blood volume leads to (1) Compensatory contraction of the vascular tree, causing pallor and decreased peripheral temperature. (2) The reabsorptive function of the kidney tubules is accelerated in order to return badly needed fluid back to the blood stream. This reduces renal excretion to the point of anuria. (3) The blood pressure falls and the pulse rises. (4) Insufficient blood flow into the right side of the heart lowers cardiac function and leads to peripheral vascular failure. (5) Peripheral vascular failure leads to tissue anoxia and to death of the patient.

It is fundamentally necessary to understand in shock that trauma to the organism produces only one basic phenomena. It renders the capillary wall pervious to the passage of the colloid, serum protein, and nothing else. The capillary wall is normally pervious to all the other elements to be lost from the blood stream. It is the accumulation of a large serum protein pool in the interstitial spaces that leads to all the other phenomena connected with shock. Any treatment undertaken for this condition must be directed at this excessive colloid accumulation within the interstitial spaces.

In order to properly understand the role of the colloid, serum protein, in traumatic shock, it is necessary to study its fundamental role in water balance and fluid exchange. Water in the human organism is gathered within three large spaces, the intravascular space, the interstitial space and the intracellular space. The chief electrolyte of the intravascular space is sodium chloride. This electrolyte passes freely to the interstitial spaces but not to the intracellular space. The chief electrolyte of the interstitial space is also sodium chloride. It again passes freely to the intravascular field but with great difficulty to the intracellular field. The chief electrolyte of the intracellular field is potassium phosphate. This electrolyte is trapped within the intracellular field, and does not easily pass out of the cell. Water passes freely between all three fields. Since the sodium chloride cannot pass into the intracellular field and since potassium phosphate cannot escape from the intracellular field it is obvious that, under normal conditions, the exchange of water is under the complete control of the concentration of sodium chloride in the interstitial and intravascular fields. The so-called

"protein-colloid gradient," on the other hand, tends to keep water constantly on the move between the three fields. This gradient is created by the differential concentration of protein colloid in the three fields and by the fact that colloids cannot traverse cell membranes under normal conditions. Due to its stability behind and between the cell membranes, colloids have about nine hundred times more attraction for water than sodium chloride. Protein colloid has its lowest concentration in the interstitial field and, therefore, there is a constant and over-present tendency for water to flow from this space to the other two spaces. The intracellular space has the highest protein-colloid content and there is a constant pull of water towards this space from the other two spaces. This constant and ever-present protection of the intracellular water is fundamental to human existence. This constant tendency of water to flow towards the tissue cells from the other two spaces is offset and balanced by two factors. First, the easily adjusted concentration of the sodium chloride electrolyte between blood stream and interstitial space, and, secondly, the hydrostatic action of the blood pressure within the arterial system. The freely movable sodium chloride hastens about and by varying its concentration equalizes the constant pull of the protein colloid. The blood pressure within the vascular tree pushes fluid out of the vascular system at the high pressured arteriole and sucks it back in at the low pressured venule. The safety valve of fluid balance is the filtration-reabsorptive mechanism of the kidneys. The kidneys remove tremendous quantities of water and electrolyte from the blood stream through filtration action of the capillary tufts. It then reabsorbs practically the entire quantity back through the tubules. By speeding up or slowing down this re-absorptive action of the kidneys, large quantities of water and electrolyte can be taken from or added to the blood volume.

It is readily seen that the abnormal accumulation of protein colloid in the interstitial spaces upsets drastically the protein colloid gradient and will attract tremendous quantities of water and salt from the blood stream, leading to the reduction of the total blood volume with subsequent disastrous results.

It is also readily seen that if shock is treated by the injection of large quantities of salt and water alone into the blood stream, nothing but disaster can be expected. The water injected will be attracted by the abnormally high colloid concentration in the interstitial spaces and quickly run out from the vascular spaces into the interstitial space further adding to the troubles of that already overloaded space.

The fundamental basis for the treatment of traumatic shock is the restoration of the serum protein content of the blood stream. Water and salt should be used only in conjunction with colloid solutions, and never alone. The shock patient can die from an excess of water if there is a deficiency of blood colloid. Colloid solution should be injected in conjunction with saline solution until the blood volume is restored and maintained within normal limits. The blood pressure and haemoglobin readings can be used to determine when this restoration is complete. The excretion of urine at 1500 c.c. in 24 hours is another crude method of gauging the adequacy of the treatment. Colloid solution should be injected in proportion of approximately 1 to 3 in its relation to saline solution. If edema is noted around the traumatized area the relative quantity of colloid is inadequate and should be increased. After restoration to normality, saline solution should be discarded and the fluid balance maintained with 5% glucose solution. The safety mechanism of the renal apparatus is more efficient in handling excessive quantities of glucose than of saline. The best colloids to use are transfusions of blood plasma, blood serum or whole blood. If not available in quantity, Gum Acacia is justified, but is a poor substitute.

The use of morphine to ease pain is justified in spite of its effect on the respiration. It should not be used in excessive amounts. The lowering of the patient's head to conserve the blood supply to the medullary centres is still used and considered of great importance. The application of heat to the shock patient has undergone some changes in our ideas. No longer do we consider excessive heat beneficial. It will dilate peripheral capillaries and offset the attempt of the contracting blood vessels to compensate for reduction of blood volume. The use of adrenalin is regarded with suspicion. The vessels are reflexly contracted to their maximum already, and spurring the straining horse may not be wise.

In ending, the case of traumatic shock with a high or normal blood pressure should be mentioned. These cases are the most treacherous encountered by the physician. In these cases the blood volume is reduced but the contraction of the vascular tree has in some way been able to maintain and even elevate the blood pressure. When these patients are given an anaesthetic the vascular tree relaxes, the blood pressure drops out of sight and the patient rapidly succumbs. Irrespective of what the blood pressure shows, if a patient's injuries are of such a nature that he should be in shock—he is in shock—and should be treated accordingly.

ANAESTHESIOLOGY

Edited by R. G. Whitehead, M.D.

Report of Meeting

The Monthly Meeting of the Winnipeg Anaesthetists' Society was held in the Medical Arts Club Room on Tuesday, November 2.

Dr. I. MacLaren Thompson, Professor of Anatomy, University of Manitoba Medical College, presented an illustrated address on "The Anatomy of the Autonomic Nervous System."

The meeting concluded with a short business session.

R. G. W.

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The meetings of the Winnipeg Anaesthetists Society are held on the first Tuesday of every month in the Medical Arts Club Rooms.

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Myanesin; A Review of the Literature

The muscle-relaxing action of a new synthetic compound, Myanesin (British Drug Houses, Limited), was first reported by two British pharmacologists, Berger and Bradley, in December, 1946. Myanesin is a glycerol ether, Alpha: Beta-dihydroxy - Y - (2 methyl phenoxy) propane, which was found after extensive research to have muscle-relaxing properties very similar in action to Curare.

Myanesin is a colorless, odorless, crystalline substance with a melting point of 70-71°C. Its water solubility at 22°C is 1.09 mgms. per 100 ml. of water. Myanesin is very soluble in alcohol and propylene glycol and urea derivatives greatly increase its solubility in water. It is a neutral solid and the PH of its solution is practically the same as that of the pure solvent. Solutions of Myanesin are stable and unaffected by light, air, cold and dilute acids and alkalis. These solutions are freely miscible with solutions of sodium chloride, glucose and derivatives of barbituric and thiobarbituric acids.

Myanesin is put up as a solution in ampoules containing 1 gm. in 10 ccs. This solution may be boiled and has antibacterial properties.

The pharmacological action of Myanesin in producing muscular relaxation, as suggested by Berger and Bradley, is due to its depressing action on reflex excitability of the spinal cord. It has little or no effect on blood pressure or respiration in ordinary muscle-relaxing doses and is effective in antagonizing strychnine convulsions and also seems to potentiate the action of barbiturates in Anaesthesia.

Mallinson reports favorably on the clinical action of Myanesin in a series of 112 cases in which the drug was given intravenously in conjunction with Sodium Pentothal-Nitrous Oxide, Sodium Pentothal-Cyclopropane, Sodium Pentothal-Nitrous Oxide-Ether and Nitrous Oxide-Ether Anaesthesia. In his opinion, this new synthetic compound has marked advantages over Curare, claiming a wider margin of safety, adequate abdominal muscle relaxation without intercostal paralysis, the potentiation of barbiturate action and an absence of bronchospasm and salivation.

Lyall reports on the use of Myanesin in 250 consecutive cases in combination with light ether, nitrous oxide or pentothal anaesthesia. When administered with light ether anaesthesia relaxation was adequate in most abdominal operations. In combination with Nitrous oxide abdominal relaxation could not always be obtained but this combination was quite satisfactory for minor manipulative procedures and other operations on the limbs. Sodium pentothal with Myanesin was successful for short abdominal procedures and of particular value in short extra-abdominal operations including dilatation and curettage, haemorrhoidectomies and manipulation of fractures, etc. He found the injection of Myanesin had little effect on heart action, although in some cases the rate appeared definitely slower and the pulse fuller. There did appear, however, a fall in both systolic and diastolic blood pressure varying from 10-25 mm. and in some elderly patients the fall was much greater.

The use of Myanesin in children's surgery, as reported by Wilson and Gordon in 100 cases of appendectomy and Davidson in 44 cases of abdominal operations, is a valuable means of therapy. Adequate abdominal relaxation with little or no respiratory depression is reported and no deleterious post-operative effects were demonstrable. The ages of the patients in these series ranged from 24 days to 12 years and the dosage from 1.0 cc to 5 cc. Adequate relaxation persisted for procedures up to 40 minutes. The drug was administered in the veins of the arms or legs or in the longitudinal sinus through the anterior fontanelle in infants.

Myanesin has been shown to have a beneficial effect in relieving spasm and pain in some spastic and hyperkinetic states. Hunter and Waterfall report on its value in control of epileptic fits and Parkinsonian tremor while Brooks and Handfield-

Jones found no effect on the relief of spasm and pain in two poliomyelitis cases.

Stephen and Chandy investigated the action of Myanesin in three groups of patients, (1) patients suffering from diseases of the extrapyramidal system; (2) those having frequent recurrent intractable pain, and (3) patients with known spinal cord lesions. The first two groups showed transient but definite abolishment of involuntary movements as seen in diseases of the basal ganglia and relief of pain of central or thalamic origin. The spasm and paraesthesias of spinal cord lesions were not affected. In addition, electroencephalographic studies carried out on seven patients showed no significant alteration in the electrical activity of the cortex with the maximum doses of Myanesin employed. No indication of cortical depression was observed. From their clinical investigation and other experiments these authors conclude that the action of Myanesin is central rather than peripheral and selective for diseases of the extra-pyramidal system and pain of central or "thalamic" origin.

More recently, Berger and Schwartz have reported on "Oral Myanesin in the Treatment of Spastic and Hyperkinetic Disorders." The oral administration of a 3.3% (wt. in vol.) solution in 20% (Vol. in Vol.) aqueous propylene glycol with syrup of cherry 20% (Vol. in Vol.) i.e. 30 cc. = 1 gm. Myanesin is stated to be just as effective in spastic states and hyperkinetic disorders as the intravenous administration without the side effects seen in this latter form of therapy.

Several complications have been reported in the administration of Myanesin including hemolysis and hemoglobinuria, nystagmus and thrombophlebitis at the site of injection. Pugh and Enderly first reported hemoglobinuria observed in three cases. In vitro and in vivo experiments showed that hemolysis took place to a drug concentration of 1:200. There was no demonstrable hemolysis with a 1% solution. Lyall reports hemolysis demonstrated in 44 of the last 50 cases of his series. There were no instances of hemoglobinuria. Slow injection is claimed to minimize hemolysis. One fatality from renal anoxia is attributed to Myanesin by Hewer and Woolmer. The patient, a young woman of 22, with a history of rheumatic fever 3 years previously, received a total of 16.3 ccs. of Myanesin while undergoing an appendectomy and pelvic exploration. Her blood pressure dropped to 70 mm. Hg. 10 minutes after the last 10 ccs. of Myanesin was administered. The patient developed hematuria on the 4th day post-operatively, followed by epileptiform convulsions on the 5th day, and died in uremia on the 6th day. The authors attribute the fall in Blood Pressure during the operation to intravascular

hemolysis with resultant anoxic damage to the kidneys.

Nystagmus, noted in numerous instances after the injection of Myanesin, is believed to be a central action similar to the nystagmus seen in the administration of barbiturates.

A localized thrombophlebitis at the site of injection has been reported in several cases by Griffith and Cullen, Stephen and Chandy and others. It is felt that this is possibly due to the solvent.

In comparing the effectiveness of Myanesin with Curare in anaesthesia, Griffith and Cullen state that Myanesin has no advantage over Curare. Lyall feels that Myanesin has some advantages over Curare, but in the extremely ill patient Curare has a more protective action than Myanesin. Davison suggests that the use of Myanesin in adult surgery is limited, but is entirely satisfactory in children's surgery particularly because of the absence of respiratory depression. In the treatment of spastic hyperkinetic disorders Berger and Schwartz feel that the benefit from oral administration of Myanesin is "much greater than with Curare, erythroidine, neostigmine or any other known remedy."

The status of intravenous Myanesin in anaesthetic and therapeutic practice has provoked considerable argument and the subject was discussed by the section of Anaesthetics of the Royal Society of Medicine on March 5, 1948. Most speakers in the discussion took a serious view of the frequency and severity of side effects of haemolysis and thrombosis whereas advocates of the agent felt that these complications could be overcome by atraumatic intravenous technique and adequate dilution of the drug or by slow injection of the 10% solution. The central action of the drug as compared with the peripheral action of Curare also received some comment. The more recent publication by Berger and Schwartz on oral administration of Myanesin may, however, prove this drug to be a valuable adjunct in the therapy of various spastic and hyperkinetic states.

References

- Berger, F. M., Bradley, W., (1946) *Brit. J. Pharmacology*, 1, 265.
Berger, F. M., Bradley, W., (1947) *Lancet*, I, 97.
Mallinson, F. B., (1947) *Lancet*, 98.
Pugh, J. I., Enderley, G. E. H., (1947) *Lancet* II, 387.
Lyall, A., (1947) *Glasgow Med. Journal*, Vol. 28, No. 10, 313.
Hewer, T. F., Woolmer, R. F., (1947) *Lancet* II, 909.
Brooks, D. M., Handfield-Jones, E., MacFarlane, R. G., Seddon, H. S., (1948) *Lancet* I, 306.
Wilson, H. B., Gordon, H. E., (1948) *Lancet* I, 367.
Hunter, A. R., Waterfall, J. M., (1948) *Lancet* I, 366.
Davidson, W. H. A., (1948) *Brit. Med. J.*, I, 544, Mar., 20, 8.
Berger, F. M. and R. P. Schwartz, (1948) *J.A.M.A.*, Vol. 37, No. 9, p. 772.
Griffith & Cullen, (1948) *Anaes. & Anal.*, Vol. 27, No. 4, 232.
R. G. W.

CANCER

Edited by D. W. Penner, M.D.

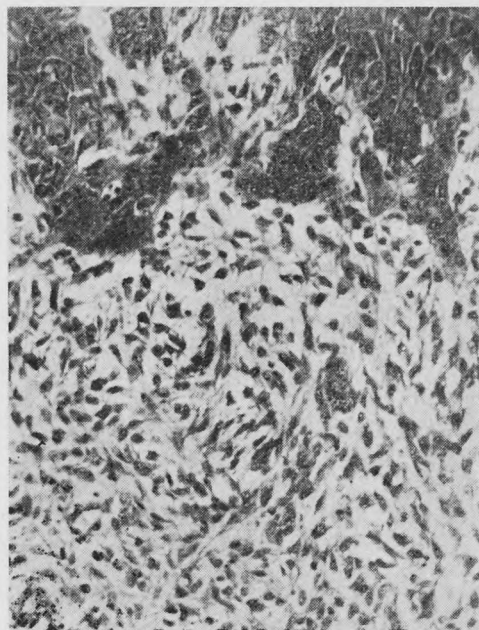
Cutaneous Neuronevi and Malignant Melanomas

The cutaneous neuronevus, commonly called a mole, is one of the commonest of the benign skin lesions. In our surgical material we see approximately 400 skin tumors per year, of these 300 are benign and 100 malignant. In the benign group, 50 are neuronevi and in the malignant group 5 are melanomas. This compares with 25 epitheliomas (not including carcinomas of lip) and 60 basal cell carcinomas. Most people have accepted the work of Pierre Masson who demonstrated the nervous tissue origin of this type of nevus. Neuronevi have a wide anatomical distribution, occur at all age groups, are pigmented and non-pigmented, many of them are hairy and some may reach a tremendous size. Apparently the non-pigmented neuronevus is not generally recognized as such clinically since in fully half of the tumors submitted to us for examination the clinical diagnosis is wrong. They are variously labelled as papillomas, hemangiomas and occasionally basal cell carcinomas.

The incidence of neuronevi developing into malignant melanomas has never been determined but from 30 to 60% of malignant melanomas are alleged to have arisen in neuronevi. Pigmented tumors in two anatomical sites warrant special mention. Lesions arising in the sole of the foot have a much less favorable clinical prognosis. All subungual tumors belonging to this group are malignant, that is, benign neuronevi are never found in a subungual location. The vast majority of neuronevi pursue a benign course, but chronic irritation, changes in the gross appearance or evidence of increasing growth are sufficient criteria for surgical removal. All such tumors removed should be subjected to histological examination. Cutaneous malignant melanomas in adults carry an extremely poor prognosis regardless of type of treatment instigated. They occur more frequently in the older age group. In our autopsy files the ages at death varied from 39 to 82 years. If the tumor occurs during pregnancy the patient rarely if ever survives. In a large series of 595 cases published by Pack et al the average 5-year survival rate for all ages was 9.7%¹. The general consensus of opinion is that the treatment of malignant melanomas is wide surgical removal with dissection of the lymph drainage areas in continuity with the primary lesion.

It has long been known but is still not generally recognized that the behavior of so called malignant melanomas in the pre-puberty age group is dif-

ferent than in adults. The majority of neuronevi occurring in children are unquestionably benign although they tend histologically to be somewhat more cellular than those seen in adults. A few present histologic features of malignant melanomas but the majority of these do not pursue a clinically malignant course. With rare exception it would appear to be correct to state that a clinically malignant melanoma never occurs before puberty. Only a few authentic cases have been reported and some of these are in the border line age group and



275X

Medium power showing malignant area in juvenile melanoma. Note the spindle cell features of the tumor and the giant cell.

have exhibited signs of puberty just after the occurrence of the tumor. In our own material of approximately 100,000 surgical specimens and 7,000 autopsies we are unaware of any cases of clinically malignant melanomas occurring prior to puberty. The various features of the so called juvenile melanoma have been thoroughly gone into in a recent publication by Spitz². This author concludes that there is a possible influence of sex-linked hormonal activation of the growth capacity of melanomas at the age of puberty and also because of the rarity of metastasis from juvenile melanomas conservative surgery would seem to be justified.

The following case is an example of juvenile melanoma. In December, 1944, a young girl, aged 12 years and 7 months, was brought to her doctor because of a change noted in a pigmented lesion on her vulva. This lesion, which had been present for some time, was noted to have recently increased in size and also laterally the surface had at times become ulcerated with some associated hemorrhage. The girl had not yet started to menstruate nor did she exhibit any other secondary sex changes. The lesion was excised and submitted for histologic examination. The microscopic examination showed most of the lesion to present features of the type of cellular neuronevus seen in childhood, however, a circumscribed 4 mm.

area in the centre showed malignant changes (see photomicrograph). On the basis of the age and the fact that the patient was still pre-puberty a diagnosis of juvenile melanoma was made. A favorable clinical course was prognosticated and further treatment was advised against. Four years later the patient is still alive and well.

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References

1. Pack, G. T., Perzik, S. L., and Scharnagel, I. M.: The Treatment of Malignant Melanoma—Report of 862 Cases. *California Med.*, 1947, 66; 283-287.
2. Spitz, Sophie: Melanomas of Childhood. *Am. Jour. of Path.*, 1948, 24; 591-609.

TUBERCULOSIS

Routine Chest Film of Patients Admitted to General Hospitals

E. L. Ross, M.D.

Medical Director, Sanatorium Board of Manitoba

The discovery of previously unknown tuberculosis of the lungs by means of X-ray surveys of apparently healthy people is now recognized as an essential part of an adequate anti-tuberculosis programme; indeed, it is the very spearhead of a preventive programme, for it finds tuberculosis at an earlier stage than any other known method of case-finding as applied to the community. In Manitoba 500,000 people have had chest films by community and industrial surveys during the past two years. During the same two years 200,000 persons in Manitoba have been admitted to general hospitals. In other words, over 10 per cent of our population is admitted annually to general hospitals for all sorts of conditions other than certain known infections, such as tuberculosis. The setting up of a tuberculosis case-finding service for this large, easily accessible group offers an excellent opportunity of extending our discovery of new cases, and making the spearhead into a broad advance along the whole line.

The X-raying of general hospital admissions gives an opportunity of discovering chest disease in many individuals and groups that cannot be reached by general or industrial X-ray surveys—for example, the mother, the maid, the self-employed tradesman or craftsman, the aged, and, most of all, the busy housewife. Women of child-bearing age have a definitely higher-than-average morbidity from tuberculosis, yet it is difficult to assemble them either for mass X-ray examination or for special individual examination. If we can catch them, incidentally, as it were, when they come into general hospital for other necessary care, or when receiving pre-natal care, we will

have gained a point in the perfection of the coverage of our preventive campaign. Tuberculosis is often considered a disease of youth. Contrary to this opinion recent mortality figures show that the highest death rate from tuberculosis occurs in the 70 and over age group. Our preventive efforts have resulted in a marked decrease in deaths among the younger persons but there has been no corresponding decline among the aged. The significance of this from the point of view of prevention is that elderly people with tuberculosis are spreaders of infection and may go along unsuspected of tuberculosis because they themselves have become tolerant of the toxins and show no symptoms or signs of the disease, or, if they do, these are likely to be masked by the infirmities of age or chronic senile conditions. Elderly people make up a relatively large proportion of general hospital admissions. Whenever one of these with unrecognized open tuberculosis is admitted to a general hospital ward he becomes a menace to fellow-patients, and doubly deadly is the menace to hospital personnel. This hazard can only be avoided by routine chest films.

Nurses entering training are X-rayed on admission to make sure they are free from tuberculosis; we can keep them free only if we are aware of every case of open or potentially open tuberculosis that is admitted to the wards of their hospital, and we can become aware only by X-raying every admission the moment they are admitted.

This matter of tuberculosis in general hospitals has been recognized for years as a problem requiring special consideration. It has been shown over and over again that the incidence of infection (as indicated by the tuberculin test) rises much more rapidly among student nurses in general hospitals than among girls of the same age-group in any other occupation. For fifteen years Dr. D. L.

Scott has been tuberculin-testing Winnipeg General Hospital nurses and he has found 28.7% enter training with a positive tuberculin reaction, but by the time of graduation 63.5% have become positive. Similar age-groups in other occupations increase their percentage of reaction only about one per cent per year. Dr. S. A. Holling of Ontario, reports that the incidence of active pulmonary tuberculosis among under-graduate nurses in that province was .55% for 1946, as compared to .17% found by mass X-ray surveys among females of the same age-group for all Ontario. This is in accord with the trend indicated by Dr. Scott's figures.

In following and looking up the literature, I am impressed with the considerable number of general hospitals in Canada and the United States where such a programme has been put into effect (20 in Ontario alone by the end of this year), and the uniformly favorable results accruing from it. There is hardly any room for doubt as to the measure's efficacy.

So far I have discussed two compelling reasons for taking X-rays of all general hospital patients and personnel, first, to serve the community as a case-finding centre; secondly, to protect the general hospital's employees from spread of tuberculous infection brought in by patients whose open tuberculosis is unsuspected and therefore undiscovered. There are other reasons. Early and accurate diagnosis of chest conditions is always an aid to the physician and an asset to the patient. Even when no tuberculosis or other chest condition is found it narrows the field of differential diagnosis and is a powerful factor in the elimination of loose and inaccurate diagnoses. Significant non-tuberculous chest conditions will be found—abnormal hearts, malignancies, mediastinal tumors, atypical pneumonias, cysts, diaphragmatic hernias, and enlarged mediastinal glands. All of these may have been unsuspected and are worthy of elimination by this simple measure. Even in themselves they are good and sufficient reason for pausing on the way through the admission-room to trip a switch and make a permanent fluorographic record.

It has been pointed out by investigators that the percentage of significant findings by routine admission chest X-rays is much higher than that found in the universally accepted blood count and urinalysis.

Admission X-ray service in a general hospital is not a formidable undertaking. Modern photo-fluorographic units which take miniature films at low cost are available, require only a few square feet of floor space, and in both installation and operation are extremely simple. A fully qualified X-ray technician is not necessary, as the whole

mechanical procedure consists of positioning the patient and pressing a button. The chest film is taken without disrobing the person and the whole procedure need take no longer than one minute. In most hospitals the X-ray department and the admitting office are distant from each other. Experience has shown that in larger hospitals with 30 or more admissions daily the fluorographic unit should be located in or beside the admitting office and operated as part of the admitting routine. As many patients as possible, certainly all except cases of critical urgency, should be X-rayed before reaching their ward and the details of a definite routine will have to be worked out for each hospital according to its space and design. The service should be under direction of the X-ray department. Films should be developed and interpreted within 24 hours of admission, or sooner, if possible. Simple procedures have been devised for identification of films and recording of findings. It should be kept in mind that this is a screening procedure and that no final diagnosis is made on the basis of small films only. If any abnormality is noted the taking of a large film is recommended. Routine chest films on admission will not replace or reduce chest work in the X-ray department, and the experience reported in this respect is that the number of regular chest films taken is greater, due to more detailed investigation of discovered abnormal conditions. In hospitals with a daily average of about 15 admissions their present X-ray machine and controls might be utilized with the addition of the fluorographic unit.

There are a number of details in connection with instituting and carrying out this service which cannot come within the scope of this presentation. I hope that within the next few months a start can be made with at least some of the larger hospitals. There are four hospitals in Manitoba that admit a total of about 50,000 patients yearly.

The ultimate objective of the programme is to have an admission chest film of patients in all hospitals, large and small, and if the number of admissions does not warrant the initial equipment expenditure it is aimed to finance the taking of standard sized films by the existing hospital X-ray machine.

This programme of X-raying hospital admissions has been discussed and considered for some time in Manitoba. The operation of units using miniature film is inexpensive but initial cost is considerable, so consequently the main obstacle has been that of financing. As you know, there is a Federal Health Grant for tuberculosis work available to assist the Province in an accelerated and intensified effort toward the eradication of tuberculosis. This grant is especially applicable to new projects.

The above outlined programme is definitely a new anti-tuberculosis project and the Sanatorium Board has applied for the use of a portion of the grant for this purpose, hoping and expecting that it will be approved by our Provincial and Federal Governments.

Summary

1. The value of a routine chest film of hospital admissions has been demonstrated in many hospitals. Such a programme has been approved by the American College of Radiology as a screening device.

2. The incidence of tuberculosis among the considerable proportion of the population admitted to hospitals is higher than among the general population.

3. The procedure makes possible the discovery of active tuberculosis in the early stages.

4. Unsuspected chronic spreaders of infection not suffering from their disease may be found.

5. Protection is provided for hospital personnel, especially nurses.

6. Many significant non-tuberculous chest conditions not producing symptoms will be discovered.

7. Routine miniature admission films do not supplant the regular X-ray examinations.

8. An impetus is given to more accurate diagnosis by physicians and attending staff.

9. The film provides a graphic addition to the patient's records and may be of value in subsequent illness.

10. The equipment takes up little room and is simple to operate.

11. The present time is appropriate insofar as the financing of this programme is concerned.

Manitoba Hospital Association,
October, 1948.

Medico-Historical

J. C. Hossack, M.D.

Dr. Ross Mitchell sent me a printed sheet which was given to him by a Hudson's Bay Company official. With it he sent the following note: "The enclosed pamphlet on Cholera may be of interest to you. As you know the disease was rife in England in 1832 and it was due to that circumstance that Dr. William Cowan came to Fort Garry in that year."

Dartmouth, September 10, 1832.

Sir:

Having now witnessed the death of many Persons from Cholera, whose lives probably might have been saved, had the premonitory symptoms been known to themselves, immediately attended to, and properly treated. I feel it my duty to send to you (as you are so far removed from Medical assistance) a statement of the primary symptoms, with the appropriate remedies, which I can confidently recommend, having now proved their efficiency, when early administered, in a very large number of cases, and corroborated by other Medical Gentlemen who have also adopted them; and they will be found perfectly safe, if the directions are attended to, in the hands of any sensible person.

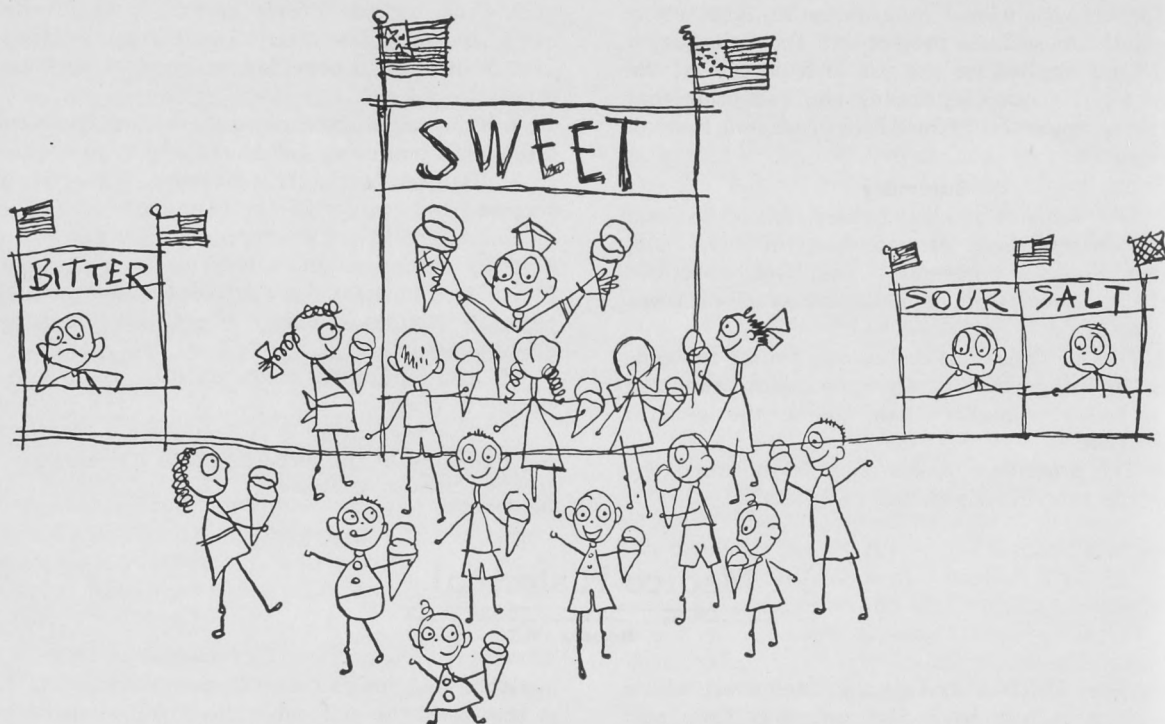
I remain,

Your obedient Servant,
Henry Hunt.

When a Person is first attacked with this disease, the mind and nerves are often greatly disturbed, the legs fail, there is a general feeling of

lassitude and fatigue, a dull, heavy weight is felt at the pit of the stomach, with a sensation of fullness, not amounting to acute pain; a dizziness in the head and confusion of ideas, an uneasiness in the bowels with a tendency to retch, and a general feeling of coldness with occasional transitory heats; at times a cold perspiration, with a great anxiety, or as my patients have expressed themselves, "feeling miserable without being ill." These symptoms continue from one hour, to twelve, gradually increasing in severity, until those that are well known succeed, such as cramp, vomiting, diarrhoea, &c. After which the case becomes so formidable, that I cannot venture to recommend any plan in a letter of this description. As soon as any of these primary symptoms come on, the person should go to bed in a flannel dress, and lie without sheets between the blankets; a bottle of hot water or a heated brick wrapt in flannel, should be placed under each armpit, and one between the legs and at the feet, the head as well as the rest of the body being covered; and two table spoonfuls of the following mixture should be given every quarter of an hour, until copious perspiration is produced; as soon as that takes place, the uneasiness, pain, and anxiety will subside, then the dose should be repeated once an hour, for three or four hours, by which time medical assistance ought to have been procured, and the treatment must then be varied according to the circumstances of each case.

Mixture: Sal Volatile, half an ounce; Water, six ounces.



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General Practitioners

Interim Report and Recommendations of the Scientific and Educational Committee

March 15, 1948

To the President and Executive of the
General Practitioners' Association of Manitoba:

The Scientific and Educational Committee of General Practitioners' Association of Manitoba, whose chief aim is to elevate the status and dignity of the general practitioner, held two meetings, on March 2, 1948, and March 18, 1948. Very constructive and stimulating discussions took place both times. As a result, the committee wishes to bring the following recommendations to the general meeting for their consideration.

1. Uniform Case Records

Whereas, there is a lack of uniformity in clinical records among medical practitioners, and a wide range of case history forms are in use, and in order to promote and encourage better records so as to improve their diagnostic and scientific value for the benefit of the patient and the doctor, be it resolved that a standardized case history form should be adopted and recommended for use by all medical practitioners.

2. Scientific Papers and Discussions

Whereas, the public expects the benefits of the recent medical advances, the general practitioner must be given every opportunity to command, maintain, and perpetuate high standards of medical knowledge, and since it is the sincere wish of this society to encourage the study, improve the practice, and elevate the standards of the general practice of medicine, by maintaining and increasing the general practitioner's interest, active participation, and self-expression in the scientific programmes at the ward rounds, clinical luncheons, conferences, tumor clinics, and whatsoever may improve the educational opportunities of the general practitioner, be it resolved that definite understanding should prevail among the programme committees of the hospital staffs, Winnipeg Medical Society, Manitoba Medical Association, and the Editorial staff of the Manitoba Medical Association Journal, whereby the general practitioners should be approached, and encouraged, and given access to participate at these functions by presentation of scientific articles, clinical cases, and participate in the discussions that follow.

3. Hospital and Outdoor Appointments

Whereas, the practice of general medicine is the broadest of all specialties, and has within its ranks some of our best medical minds, the general

practitioner has at all times served his honored and rightful place in the undergraduate teaching; such appointments being the recognition of time spent in general practice, standards of work, systematic clinical records, academic standing and teaching ability; be it resolved that a survey be made of all teaching hospitals in Greater Winnipeg, with the view of ascertaining how many general practitioners hold appointments on the various teaching staffs and that further appointments be made both on the indoor and the outdoor staffs and maintained on equal footing and prestige with that of their specialist colleagues, if the general practice is to attract and keep men of the highest calibre within its ranks.

4. Clinics to be Conducted by Teaching Staff

Whereas, the clinical teaching in the hospitals is the chief function of the hospital teaching staff, and whereas, the resident internes have no personal experience in medical practice outside the institution, but are often called upon to clinic to the medical students and nurses, such practice is not in the best academic interests, be it resolved that teaching in the hospitals, should not be relegated to the resident internes, or to the medical men without staff appointment.

5. Consideration Re: Practice for Higher Degrees

Whereas, the present requirements for the candidates seeking higher degrees or certification, are based primarily on the institutional work, while such qualification may be ready access to the young graduates, on the contrary, this being the chief obstacle to those who were away from teaching centres for a number of years, during which time they were pursuing in private practice, and whereas, no credit has been forthcoming for such time spent in active practice, which is indispensable for true fulfillment and enrichment of any specialty, be it resolved that due recognition should be granted by the R.C.P. & S. (C) or Specialty Boards for the time devoted to general practice of medicine along with the standard of work and the clinical records in lieu of the institutional work.

Respectfully submitted,

V. F. Bachynski, M.D., Chairman.

Report of the Scientific and Educational Committee, Oct. 19, 1948

To the President and Executive of the
General Practitioners' Association of Manitoba:

This committee is composed of the following members: Drs. Bachynski, Sigurdson, S. Hershfield, Markowits, Benoit and Newman. Its initial

work was the "Interim Report and Recommendations" submitted to the general practitioners' meeting in March, 1948. Some of those recommendations have been acted upon.

Voluminous correspondence took place between this organization and the American Academy of General Practice which culminated in sending Dr. Sigurdson as our official representative to their annual meeting in Chicago held last June. His report appeared in the September issue of the Manitoba Medical Review. Full proceedings were published by the American Academy of General Practice in "General Practice News," Vol. 1, No. 6, July, 1948.

Meeting of the Executive of General Practitioners with Dr. W. Wilson took place in April, 1948, in Winnipeg. Lengthy discussion on immediate problems facing the general practitioners was the main theme of their deliberations. He also addressed the Winnipeg Medical Society on the subject of establishing of a General Practitioners' section within the Canadian Medical Association. Dr. Wilson has been exploring the possibilities of raising funds to grant bursaries to general practitioners for original research. He also brought up the question of certification of general practitioners.

Three representatives from Manitoba Medical Association to the Canadian Medical Association Meeting in Toronto were elected from the General Practitioners' Association of Manitoba at a general meeting held on Feb. 18, 1948: Drs. A. Wilson, Jacks and Bachynski. "The Role of the General Practitioner at the 1948 Canadian Medical Association Meeting in Toronto" appeared in the Manitoba Medical Review, October, 1948 issue.

Never within the history of the Canadian Medical Association have the Members of the General Council shown more genuine interest in the welfare of the general practitioner than at that meeting. It is realized that the medical profession, without the family doctor, is like a business concern without a general manager. The public would be left to shop around among the specialists without an intelligent guide.

Dr. F. Young presented a scientific paper this afternoon on "Non-Penetrating Traumatic Lesions of the Heart." He was chosen by the General Practitioners' Association of Manitoba to contribute their part to the Scientific Programme. This paper showed a good deal of original investigation, and was most interesting and instructive.

Dr. L. Sigurdson is conducting a survey of the General Practitioners who are serving on the University staffs, also on the staffs of the teaching and non-teaching hospitals.

General Observations

In the preamble of the American Academy of General Practice we find this: "General Practice is the backbone of the finest medical system the world has ever known. It is economically and medically the soundest means of distributing care to the masses of the people. The fine things in general practice could not be preserved and the medical science and art could not be advanced without the organized effort of the General Practitioners."

The medical profession was about to discard one of its greatest servants, the general practitioner, but the threat of socialized medicine has wakened us up. If the general practitioner does not survive there is little chance that a free medical profession will survive.

The chief aim of every General Practitioners Association should be to accomplish the fundamental purpose of advancing the cause of the general practice of medicine by:

(a) Creating incentive and inducement to maintain proficiency in the general practice of medicine;

(b) Developing a sense of unity and co-operation among the general practitioners;

(c) Improving the educational opportunities of the general practitioner;

(d) Making the general practice of medicine a field in which the highest abilities may find opportunities as attractive as in any field into which physicians may enter with expectation of making work in that field the career of their entire lives.

General Practice of medicine should come to occupy the position which will provide the most adequate medical care that the public requires.

The first consideration of a young doctor should be, where can he do the most good to society. Recent process of evolution brought about drastic changes in medical practice resulting in comparative scarcity and maldistribution of general practitioners. Subsidizing of young men to go into rural general practice has not yielded the results hoped for. This is the result of the type of training offered and the complacent attitude of our medical schools and hospitals which has created in him the inferiority complex and this, more than anything, has been threatening the usefulness of the general practitioner. It is time to clean our own house and stop segregating the specialized sheep from the general goats. "There is glory enough for us all." Attempt must be made to bring the general practitioner back to the level in medicine that he justly deserves.

"Common things are common." The medical needs of our country could be satisfactorily met if approximately 75% of our graduates would plan for general practice. But the general practitioner

must be restored to his rightful place as the keystone of the medical profession.

If his status is not protected, then our whole system of organized medicine is threatened.

Medical Education

Everchanging conditions of general practice necessitates that Medical schools conform to these in their undergraduate medical teaching. Reforms in medical education are needed and must be brought about by organized medicine itself, and not wait for outside pressure.

It is the duty of the medical schools to produce well trained men for general practice.

A change in the teaching methods is necessary, so that the students may be made to realize the importance and the advantages of general practice. Up to now most medical schools have, whether intentionally, or not, encouraged their students to specialize. The teaching is done by specialists and the students cannot help being influenced by their example.

How can you make general practitioners out of medical students when they are exposed entirely to specialists? Somewhere in his training the medical student should be exposed to the general practitioner as a teacher.

In the words of W. M. Johnson, Bowman Gray School of Medicine of Wake Forest College: "Another potent reason for the trend to specialization is to be found in the type of training offered in most of our medical schools and hospitals. Even in those institutions which profess to train men for general practice, it is hard for the students and house officers to escape the subtle influence of knowing that certification is required of their teachers and of the hospital staff members. Even though those men may pay lip service to the family doctor, they have themselves become specialists. The student can hardly be blamed for thinking, when one of his preceptors advises him to go into general practice. "What you are speaks so loud that I cannot hear what you say."

There is something lacking in the training of men for general practice. This may partly be rectified by appointment of general practitioners on University teaching staffs, and placing of students during the summer months with general practitioners.

A few medical schools, e.g., Bowman Gray School of Medicine of Wake Forest College, in North Carolina, and the University of Louisville, now include courses in general practice in their curriculum, and some of the larger hospitals are offering rotating internships planned especially to train men for general practice.

At present, specialty training dominates most medical schools. But there is a lack of post-

graduate training and refresher courses designed for a general practitioner. This should be the chief requisite of every modern school, in order to improve the quality of general practice. Clinical teaching should be done by men in active practice and should include general practitioners in its personnel.

It is the hope that in the future all medical schools will see fit to put a chair of general practice as some have already done. Such a happy combination will:

(a) Encourage and assist medical schools and hospitals to maintain and develop adequate courses and facilities for the education and training of general practitioners;

(b) Encourage and assist in providing post-graduate study for general practitioners in medicine and surgery;

(c) Encourage and assist practicing physicians and surgeons to participate in such training.

Hospitals

The hospitals also have an enormous responsibility in training of students in general practice.

The establishment of rotating internship or residencies to ensure fairly thorough grounding in the essentials of family practice, has been put into practice in a good many hospitals.

General practitioners must be included in, and not excluded from, hospital staffs. There is a tendency of the hospitals to close their doors to general practitioners. Easier access to the hospitals must be accorded.

Certification of General Practitioners

A general practitioner is one who does not limit himself to one field of medicine. He is a man who should be well trained in all fields of medicine and does not lose sight of other parts of the body while trying to treat one. He does assume responsibility for the care of the families, very much as a general contractor would assume responsibility for the construction of a building.

A general practitioner, although he must know the fundamentals of all medical specialties, and thereby practice the broadest specialty in medicine, may limit his work as much or as little as he chooses.

It is realized that a doctor may take a particular interest in one line, be it medicine, obstetrics or surgery; he studies this more and becomes more proficient than his fellow practitioner. As time goes on he may desire to enter the specialty, taking with him a sound background he acquired in general practice.

Because of the proficiency of such men in particular fields of general practice through their experience and incentive to keep up with the advances by reading and post-graduate courses, it

has been suggested that standards of recognition be instituted such as certification in any line of general practice that he is proficient in, and granted to those general practitioners who have demonstrated their ability and willingness to keep abreast of the advances of medical science.

Certification in the chosen field would stimulate the men in general practice to keep abreast of medical progress, and it would do much to raise their status and prestige. This would stop the drift away, but on the contrary, would attract many of our best doctors into general practice, a field which has included, and should include the best minds in medicine.

It would not defeat the purpose for which it was created. It would offer a real test of a man's ability surpassing some of the specialty boards already existing. It would attract the most able men.

This would protect the right of the General Practitioner to engage in Medical and Surgical procedures for which he is qualified by training and experience.

An Academy of General Practice within the Canadian Medical Association should be created which would act as a certification board. This

would mean to the general practitioner what the College of Surgeons is to the surgeon.

It would be a responsible body to undertake the setting up and the maintenance of the standards.

There is increasing sentiment for recognizing time spent in general practice as being good preparation for a specialty. It is hoped that specialty boards will liberalize their requirements in order to give credit for general practice.

The specialist should begin as a general practitioner and gradually grow into his specialty.

Specialty boards should give credit for four or five years in practice as preparation for specialty boards.

Most successful specialists have had a broad foundation for their specialty by first engaging in general practice.

We hope to see the specialty boards demand of their candidates certain amount of general practice before they are allowed to take up specialty work. In the future, we hope, this will be one of their requirements.

All of which is respectfully submitted.

V. F. Bachynski, M.D., Chairman.

WINNIPEG MEDICAL SOCIETY

Reported by Arthur E. Childe, M.D.

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Owing to the change in date of the Annual Meeting of the Manitoba Medical Association, the first meeting of the 1948-1949 session of the Winnipeg Medical Society was held two weeks earlier than usual, on October 8th, 1948.

The first item on the programme was a case report by Dr. Harry Medovy entitled "Juvenile Relapsing Chronic Subdural Hematoma." The speaker was, as always, most interesting and informative not to mention entertaining, so that by

the end of the presentation almost everyone in the audience had a very clear conception of what this rare condition really represented, even though they did not necessarily remember its name. The patient in question was a boy, aged 9 years, who had been under intermittent observation from birth. The most important findings on examination were bilateral papilledema and a hard bulge in the left temporal region. There had been some recent change in social habits. Radiographs of the skull clearly showed that the left sided cranial bulge was due to general enlargement of the middle fossa on this side plus thinning and outward bulging of the squama of the temporal bone and of the adjacent portions of the frontal and parietal bones. These changes were obviously due to long continued local pressure and consequently a subdural hematoma was suspected. Exploration by Dr. Hugh Cameron confirmed the pre-operative diagnosis and showed that two separate hematomas existed, one evidently much older than the other. They were so large that they had destroyed a considerable portion of the left frontal lobe. Following operation the papilledema rapidly disappeared. The boy who had become quarrelsome and difficult to manage now has a sunny disposition and gets along well with his playmates.

The main paper of the evening was presented by Dr. Irvine McQuarrie, Professor of Pediatrics, University of Minnesota, Minneapolis, Minn., who was introduced by Professor Bruce Chown. The title of his paper was "Convulsive Disorders in Childhood." Professor McQuarrie is an authority on this subject and his presentation was a scholarly discussion of this very important problem. It included much original work of his own over the past many years. A rather detailed summary is contained in the Pediatric Section of the November issue of the Manitoba Medical Review, so it will not be repeated here.

The December meeting will be held on Friday the seventeenth. This is sufficiently removed from Christmas so that it should not seriously interfere with holiday festivities and it is hoped that there will be a large turnout. Under the able guidance of Professor J. D. Adamson the programme will be devoted to the discussion of Streptomycin. J. D., who is the chairman of the D.V.A. Committee on Streptomycin for Canada, has recently attended the Sixth Streptomycin Conference which was held in St. Paul, Minnesota. He is literally bulging with all the latest information on this subject. He will be aided and abetted by Drs. A. L. Paine and A. C. Sinclair who will describe the use of this drug in pulmonary cases and by Dr. David Swartz who will outline its use in urinary infections. The discussion will be

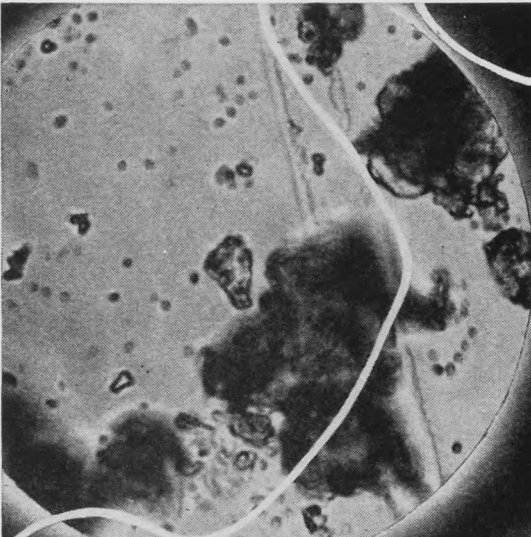
opened by Drs. Bruce Chown and E. L. Ross. At least half an hour will be allowed for questions which are to be submitted in written form, so that all may feel free to participate.

The programme committee is trying to plan this winter's meetings so that they will adjourn for refreshments no later than 10.30 p.m. and President Macpherson has agreed to be firm with verbose speakers who threaten to disrupt this schedule. It is therefore hoped that members will endeavor to be in their seats promptly by 8.15 p.m. Although the seats in Theatre A are much more comfortable than they were before the recent alterations in the Medical College they grow hard as the evening wears by and the concentration of the listeners tends to vary inversely as the square of the hardness.

All the programmes for the current session have not yet been arranged so the Programme Committee requests that members who have material that they wish to present, contact them as soon as possible. Barring atomic bombs or earthquakes, meetings will be held regularly on the third Friday of each month, but one or more additional special meetings may well be arranged if outstanding guest speakers become available.

The Council of the Winnipeg Medical Society met in the Medical Arts Club Rooms on Wednesday, October 6th, 1948. Various items of business were discussed. A letter from Dr. J. Graf was read requesting permission to form a Pediatric Section of the Winnipeg Medical Society. This was unanimously approved by the Council and the Secretary was instructed to write Dr. Graf accordingly. At the suggestion of Dr. Holland it was decided to appoint some member of the Programme Committee other than the Chairman, to be a representative of the Editorial Staff of the Manitoba Medical Review. Dr. L. R. Coke has kindly consented to act in this capacity, commencing November 15th, 1948.

Dr. H. D. Kitchen reports that arrangements have again been made for doctors to curl on Wednesday at 12.30 p.m. Four sheets of ice will be available at the Granite Curling Rink, as soon as the weather is sufficiently cold. This has proven to be a most enjoyable form of relaxation in the past and it is expected that it will be even more successful this year. Unfortunately it may not be possible to accommodate all who wish to curl, but preference will be given to those who took part last year. Application lists will be posted in various hospitals, so please watch your notice boards closely, unless you wish to grow fat through lack of exercise. A word of commendation to Kitch., for his perennial interest and efforts in this connection is long overdue.



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Supplementary Report on Negotiations With the Workmen's Compensation Board of Manitoba

After over two years of negotiations with the Workmen's Compensation Board of Manitoba, this committee is, we feel, able to report at least a measure of progress. Several meetings have been held in which policy rather than fees has been discussed and, we believe, a somewhat better understanding arrived at. But to say that the negotiations have been entirely satisfactory would be toying with the truth, since much that was desired has not been attained.

We started negotiations on the basis of an estimated 50% increase of all fees but a compromise upon a lesser percentage was finally agreed upon. Nevertheless, it is a step forward, and the next two years will reveal more accurately what the actual percentage increase was. This element of time is due to the fact that actual figures are not brought down for the current year until the next succeeding year has been completed. At present there is no way of estimating the actual percentage increase on the basis of the fee schedule since many other factors enter into the picture. This committee feels, if the percentage increase at that time is not adequate, then negotiations be reopened. At the same time more facts and much more experience will have been acquired for further negotiations.

To put the case in a more chronological order a proposed fee schedule was first prepared by your committee. A meeting with Dr. Fraser and Mr. Fletcher was then held to bring this schedule into line which would be acceptable to the Board and to the profession. After spending several hours on less than one page of items this plan was abandoned and the Board offered to make a counter proposal. For this purpose the Board engaged the services of three disinterested doctors to act in an advisory capacity. Subsequently, the Board submitted its counter proposal. Your committee studied this counter proposal and subsequently again met with the Board. At that time the X-ray schedule was not included nor dealt with, but again much time was consumed in going over the same items previously dealt with. These items include in the main, office, house and hospital calls, dressings, consultations, assistant's fees, etc. Items which it was felt were probably the greatest source of contention. One procedure which, it was felt, had previously been grossly out of line was Herniotomy which stood at \$60.00 for one hernia and \$80.00 for a double hernia. This was increased to \$80.00 and \$125.00 respectively. Again it was felt that more could not be accom-

plished and the balance of the schedule was accepted.

This schedule, then, consists of five typewritten sheets, which, we hope, covers mostly, if not entirely, all the procedures accepted as compensable by the Board. Such an improved schedule clarifies many procedures and largely eliminates the assessing of an account on the basis of a procedure of comparable magnitude.

Having completed that aspect of it, another meeting was held at which the Radiological fee schedule was dealt with. A counter proposal had been received from the Board which was felt to be unacceptable. It allowed for a small increase in most of the fees and the schedule was much more complete. But the Board intended this schedule to apply to the certified Radiologist and the general practitioner was to receive 75% of the schedule. Actually, on the basis of 75%, the general practitioner was getting less than he previously had. Finally, an agreement was arrived at whereby the schedule applied to both the specialist and the general practitioner.

However, it had previously been requested that the radiologist be paid 25% of the regional fee for interpreting films for the Board, whereas such films had been read on a monthly fee basis. This procedure had been started about three years ago and was a direct negotiation between the radiologist and the Board. The Board's attitude towards such a 25% fee was that it would increase the overall cost of X-rays to such an extent that they could not accept the arrangement of an equal fee for specialist and general practitioner, so the monthly arrangement was left unaltered at present.

Another matter which was stressed and agreed upon, was, that in the future the Board would not negotiate with or enter into any arrangements with any group of specialists, but would do all its negotiating through the executive of the Manitoba Medical Association. This, we believe, to be absolutely fair and may, in the future, prevent considerable misunderstanding and avoid certain pitfalls.

This, then, terminated our negotiations, and we now offer you a more detailed fee schedule with a variable increase. The regulations have been extended and we hope will facilitate making reports and rendering accounts. The fee schedule will become operable as of October 1, 1948, for work done on and after that date, and it is sincerely hoped that the action of this committee meets with your approval.

Respectfully submitted,

H. FUNK, M.D.,

Chairman of the
Negotiating Committee.



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BOOK REVIEWS

Essentials of Dermatology, by Norman Tobias, M.D. Assistant Professor of Dermatology, St. Louis University; Assistant Dermatologist, Firmin Desloge and St. Mary's Hospitals; Visiting Dermatologist, St. Louis City Sanitarium; Fellow, American Academy of Dermatology and Syphilology; Diplomate, American Board of Dermatology and Syphilology; Visiting Physician in the Department of Dermatology at the St. Louis City Hospital. Third Edition. 181 Illustrations, including 6 subjects in color on 3 plates. J. B. Lippincott Company, Montreal, Canada. Price \$6.75.

This brief treatise on diseases of the skin was conceived with the idea of placing a handy volume at the disposal of general practitioners and medical students who often have neither time nor inclination to refer to the larger standard dermatologic textbooks. The author has attempted to present the growing subject of Dermatology completely and concisely without the sacrifice of detail. Histologic descriptions and theoretic considerations have been reduced to a minimum to fit in with the scope of the book. During the past ten years so many advances have been made in allied fields that Dermatology has benefited considerably. Wherever possible these newer subjects are up-to-date.

Since most skin diseases look alike to the beginner, differential diagnosis has been stressed and diagnostic features emphasized. The classification of the various types of dermatoses used in this book is based on the clinical, pathologic and etiologic concepts accepted at the present time.

As far as practical, each disease is discussed from the standpoint of internal medicine to eliminate the notion prevalent among medical students that Dermatology is a collection of Latin and Greek names and complex prescriptions.

The Chinese proverb "one picture is worth a thousand words," is perhaps more applicable to Dermatology than to any other specialty in medicine. On the other hand, the best photographs and the best textbooks do not take the place of clinical observation when based on intelligent thinking. The author has included as many photographs of the common diseases as possible in the limited scope of this book.

A third edition of "Essentials of Dermatology" has become necessary to enable the author to bring the subject up to date and to introduce new material in response to suggestions from colleagues and reviewers. As the years pass and experience widens, the new material of today becomes obsolete tomorrow in many instances.

This edition stresses the danger of local sulfonamide medication, overtreatment of many conditions, the need for less routine x-ray therapy in dermatology, and the importance of considering the patient as a whole rather than focusing attention on the skin alone.

Special revision has been made of the chapters on occupational dermatitis, syphilis and ringworm of the scalp.

Many new photographs have been added and old ones replaced with better ones.

American Practitioner

The first number (September) of the third volume of the American Practitioner is at hand. This is a most useful periodical directed especially to the general practitioner and for the purpose of giving him authoritative information and advice on modern practice. Here are the contents of this number:

Life Situations, Emotions and Gastric Function: A Summary by Stewart Wolf, M.D., and Harold G. Wolff, M.D., New York, New York. Not since the days of Beaumont and Alexis St. Martin has a study of a patient with gastric fistula yielded so much important information on the physiology of the stomach and gastric secretion. In the present study all the knowledge of medicine added since Beaumont's time has been brought to bear on the examinations and tests made possible by the existence of the fistula, and the result has been an important advance in our understanding of disease of the stomach and disorders of its digestive function. The paper presents in excellent fashion a summary of a great many observations.

Diagnosis and Treatment of Toxic Goiter, by Edson F. Fowler, M.D., Chicago, Illinois. New drugs useful in the management of thyrotoxicosis have extended the surgical attack with increasing safety. This paper brings up to date the treatment of toxic states of the thyroid gland.

Edema of the Lungs, by Alvan L. Barach, M.D., New York, New York. Pulmonary edema produces a swiftly developing anoxia as the result of transudation of serous fluid from the pulmonary capillaries into the alveoli of the lungs. It is one of the commonest causes of a fatal outcome in diseases of the heart, lungs, and brain. A different form of pulmonary edema takes place in patients with congestive heart failure in which passive pulmonary congestion is present with scattered areas of edema in the alveoli; this type of chronic alveolar edema may continue for long periods without ever changing over to the entity known as acute

edema of the lungs, in which widespread moisture suddenly appears in both lungs. Despite the fairly uniform clinical picture, the pathogenesis of acute pulmonary edema varies widely, considerable uncertainty being manifested in the literature as to its mode of production as well as its treatment. The pathologic physiology and therapy of the condition are described in the disease states in which it mainly occurs.

The Value of Conservative Surgery of the Pelvic Organs, by Willard M. Allen, M.D., St. Louis, Missouri. Wasteful surgery, insofar as the ovaries and the uterus are concerned, is so common that it would seem almost unnecessary to re-emphasize it. However, in this excellent paper the author strongly warns against needless pelvic surgery, pointing to the serious physiologic and psychologic trauma of ill-considered operation.

Newer Narcotics, by Nathan B. Eddy, M.D., Federal Security Agency, National Institute of Health, Washington, D.C. The great activity and the rapid progress in the field of synthesis and development of new analgesic compounds in the morphine group, and other substances with similar action, makes it imperative that the practitioner acquaint himself sufficiently with these substances so that he may use intelligently and properly those

which are made available to him. The present article from an authoritative source will be very helpful.

Cases From the Medical Grand Rounds, Massachusetts General Hospital. Edited by John B. Stanbury, M.D., Boston, Mass. Pneumothorax, Coarctation of the Aorta and Henoch's Purpura.

What's Your Diagnosis? A case history is given in sufficient detail for the doctor to give the right answer. (This is given on another page).

Case Report, Psychiatric Conference. Edited by Stanley Cobb, M.D., Boston, Mass. These cases are chosen to illustrate the relation between psychiatric and medical factors in the production of symptoms. They are part of the Harvard teaching on Psychiatric and Children's Medical Services of the Massachusetts General Hospital and publication is made possible by a grant from the Josiah Macy, Jr., Foundation.

Asymptomatic Bilateral Polycystic Disease of the Kidneys and Congenital Absence of the Gall-bladder. Report of Case in a 70-year-old patient with Pancreatic Carcinoma, by Capt. Lorenz E. Zimmerman, M.C., U.S.A., Washington, D.C.

Published by J. B. Lippincott Co., Montreal. \$11.10 per year.

OBITUARY

Reported by Ross Mitchell, M.D.

Dr. John Douglas McQueen

Dr. John Douglas McQueen, late head of the department of Obstetrics and Gynecology of the Faculty of Medicine, University of Manitoba, died on October 17 at the age of 61. Two or three years ago he suffered from a coronary attack which to some extent limited his activities but he saw his patients at the Winnipeg General Hospital two days before his death.

From the time of his graduation from Manitoba College in 1909 he gave evidence of leadership. He was acting medical superintendent of the Winnipeg General Hospital, then took postgraduate work in the Women's Hospital of New York City. On his return to Winnipeg he engaged in practice and was a member of No. 4 Cavalry Field Ambulance. When war broke out in 1914 he joined the first contingent of the C.A.M.C. and served as captain with the 3rd Canadian Field Ambulance in France. In March, 1916, he returned to become commanding officer of the 11th (University) Canadian Field Ambulance. From 1917 to 1919 he was in command at Bushey Park Military Hospital in England and on his return was attached to the Soldiers' Civil Re-establishment. For his services in the field he was twice mentioned in despatches and

received the D.S.O.

He helped to organize the first prenatal clinic at the Winnipeg General Hospital and rose to full professorship in obstetrics and gynecology in 1939, a post he held until his retirement in 1946.

His activities were not confined to a narrow field. He was president of Manitoba Medical Association and, for several years, chairman of the Maternal Welfare Committee of the Canadian Medical Association. He was also a Vice-President of the Royal College of Physicians and Surgeons of Canada, and a Fellow of the American College of Surgeons, and Honorary President of the Manitoba Medical Students' Association.

Dr. McQueen is survived by his widow and his daughter, Dr. Roberta (Mrs. R. W. Keys), of Toronto, and two sisters.

These are the bare outlines of his career and they do not show the real character of the man. He shunned publicity and only his more intimate friends knew his thoroughness, his singleness of purpose and a devotion to high ideals which did not prevent him from being a real human being and a good companion. His truest reward was not in the honors bestowed upon him, but in the confidence and trust of his patients.

EDITORIAL

J. C. Hossack, M.D., C.M. (Man.), Editor



Christmas

Once again the naked trees, shivering in the cold wind, remind us of the approach of Christmas—that all too brief season when men's hearts are at their warmest. Strangely enough, even in ancient times this was a season of peace and goodwill. Then, for a few days, slaves were permitted to enjoy the privileges of freemen, gifts were exchanged between friends, and in all hearts burned a yearning for the Golden Age. To the custom of this ancient usage, for us has been added the promise of Bethlehem; and in our longing to see the universal rule of kindness we practice it ourselves, even if only for a day.

Then we think of our friends and find that we can think of none who are not friends, for an upsurge of fellow-feeling leaves us no enemies. Then we think also of those to whom fortune has been less kind than to ourselves, and we try to mend things for them so that everyone may enjoy the day's magic. And then, alas, like a little candle, scarce lit ere it is guttering in its socket, the flame flickers and is out.

"I will honour Christmas in my heart" wrote Dickens "and try to keep it all the year" for, as he writes again, "It is a good time; a kind, forgiving, charitable time." With feelings such as these each one thinks, for a little while at least, of ways whereby his good will can be extended, and seeks, in these moments of full-hearted sympathy, a way to reach into the coming year so that the Spirit of Christmas may live longer than a day.

Perhaps at such a time one's thoughts may turn to those of our own calling upon whom fortune has ceased to smile. And no object of thought is more proper at such a time. Ours is a brotherhood. We are fellow-workers rather than competitors and so the misfortune of one is the concern of all. There are amongst us, as there must be in every body of men, the generous, the self-sacrificing, the unworldly, who by virtue of these qualities give us our good name but, also by virtue of them, are liable to fall on evil days. Then is the time for us to show how closely we are bound together by ties almost as strong as those of blood.

But mere expression of sympathy, however sincere, will not help a thin purse. And so, as you will remember, about two years ago Walter Tisdale and Ross Mitchell established a Benevolent Fund for the assistance of those who needed help. Receipts and disbursements are in the hands of Ross

Mitchell, Walter Tisdale, Anna Wilson, Pat McNulty and young Gordon Fahrni. Those who give and those who receive get no public mention. A receipt will be given and this will satisfy the tax gatherer.

Now, when the spirit of Christmas is in the air and in men's hearts, give a thought to those who now or in the future may suffer from adversity and, as you do so, think also of the means whereby you can relieve their necessities even though you do not know whom you may help, just as those who are helped know not by whom they are helped. Thus will you not only honour Christmas in your heart but keep it all the year. The treasurer is Pat McNulty.

The Caduceus

I have before me a copy of the latest issue of the University of Manitoba Medical Journal. It is a very satisfactory product of student activity. You should subscribe to it (\$2.00 for four numbers). The closer you are to your college years the easier will you remember the financial difficulties that beset student efforts. You will remember, also, how much you appreciated the help given by the oldsters. Well, you are the oldsters now and here is your chance to make young (and enthusiastic) hearts happy.



On the cover of the U.M.M.J. is the coat of arms of the Medical School which a page in the College of Heralds might blazon thus: on a field, argent, divided per chevron, sable, two hearts, gules, in the chief, that in the sinister chief, pointed, sable and in the base a caduceus proper. That is

to say on a white or silver background there is a lance corporal's stripe in black with two hearts above it, the left sided one being blackish, and below the stripe a caduceus in its natural colors.

I do not know who was responsible for this device but I am certain that the College of Heraldry had no hand in it. The two hearts probably represent respectively the heart of the physician (the unspotted one) and the heart of the surgeon which I merely suggest is the one that has the black spot on it. The chevron in black (heraldically "sable") hints that if one can bring a sufficient number of lances to bear upon a sufficient number of bodies (corpora) the result will be a sufficient number of sables to satisfy any "little woman." All this, of course, is as it may be. I'm concerned with the caduceus. The reason for my certainty that the College of Heraldry was not consulted, is the presence of this insigne which has nothing to do with medicine, for the caduceus was an acoutrement of Mercury, who as messenger of the gods was equipped with winged shoes, a winged hat and a winged rod so that he could fly upon his errands.

Although bearing messages for the gods was the first and chiefest of his offices, Mercury also swept the room where the gods supped, and made the beds, and underwent many other like servile employments. He also attended upon dying persons to unloose their souls from the chains of the body and carry them to hell. He also revived and put into new bodies those souls that had completed their full time in the Elysian fields.

His qualities were as many and as remarkable as his offices. They say that he was the inventor of letters. He excelled in eloquence inasmuch that the Greeks called him Hermes from his skill in interpreting or explaining. He is reported to have been the inventor of contracts, weights, and measures; to have taught the arts of buying, selling, bargaining, and to have received the name of Mercury from his understanding of merchandise. Hence he is accounted the god of the merchants and the god of gain.

In the art of thieving he certainly excelled all the sharpers that ever were or will be, for he is the very prince and god of thieves. The very day on which he was born he stole some cattle from King Admetus' herd, although Apollo was keeper of them. Apollo complained much of the theft and bent his bow against him but in the meantime Mercury stole even his arrows from him. While he was yet an infant he was entertained by Vulcan but stole his tools from him. Venus' girdle he took away while she embraced him. He stole Jupiter's sceptre and would have thieved away his thunder also but that he feared it might burn him.

Mercury was very skillful in making peace and

for that reason was sometimes painted with chains of gold flowing from his mouth with which he linked together the minds of those that heard him. And he pacified not only mortal men but also the immortal gods of heaven and hell, for whenever they quarreled among themselves, he composed their differences.


This faculty of pacification is signified by the rod he holds in his hand, and which he had from Apollo to whom he had given a harp. This rod had the wonderful faculty of deciding all controversies. Its virtue was first discovered by Mercury when, seeing two serpents fighting, he put his rod between them, and reconciled them so perfectly that they mutually embraced each other and stuck to the rod which is called "Caduceus."

And now let me tell you about some of the actions of Mercury. He had a son, by his sister Venus, called Hermaphroditus who was a great hunter. In the woods where he frequented lived a nymph called Salmacis who greatly admired and fell in love with him for he was very beautiful. But he was a great woman-hater and while she often tempted him, she was as often repulsed. Yet she did not despair but lay in ambush near a fountain where he often bathed and, when he was in the water, she leaped in to him but could not overcome his extraordinary modesty. Thereupon it is said, he prayed to the gods that the bodies of both might become one, which prayer was granted. Hermaphroditus was amazed when he saw the change in his body and asked that, for his comfort, some other person be made like him and this request also he obtained for whoever bathed in that fountain became a Hermaphroditus and had both sexes.

There is another tale worth telling about Admetus' cattle which he stole from Apollo, their keeper. A herdsman, whose name was Battus, witnessed the theft and when Mercury saw that he was discovered he asked Battus to say nothing and gave him a "delicate" cow. Battus promised secrecy but Mercury was not certain that he could be trusted and, putting on another shape, came to him again and asked about the cows, whether he saw them or knew the place where they were concealed. Battus denied it, but Mercury, pressing him hard, promised that he would give him both a cow and a bull if he would discover it. With this promise Battus was overcome. Whereupon Mercury was enraged and, laying aside his disguise turned Battus into a stone called Index.

The ancients used to set up statues where the roads crossed and these statues they called Indices, because with an arm or finger held out they showed the way to this place or that. And the index which you see here points to the place whither you should send your two dollars subscription to the U.M.M.J. You may not get either

of the first two numbers because the supply on hand is limited. But you will get the other two and in any case you will get a receipt which will be useful for Income Tax purposes.

 University of Manitoba Medical Journal,
Medical College Buildings,
Bannatyne Avenue, Winnipeg.

Letter to the Editor

17 Trevor Place s. W.7,

Sir:

I am an Honorary Member of the M.M.A. who greatly appreciates the distinction and not least the regular receipt of your Review. To many of your members I am unknown, but those who took part in the magnificent welcome given to the B.M.A. in 1930 will, I hope, remember me as I gratefully remember them. As a bit of an expert in the organization of annual meetings, I can honestly say that Winnipeg's effort equalled the best I have known. We were made "as welcome as the flowers in May" and much of the credit was due to my dear old friends Harvey Smith and J. D. Adamson.

I have noted with pleasure the growth of the Review in size and in interest, not least under your vigorous editorship. I cannot say I read **all** of it, for alas! much of the scientific language is Greek to an old "back number." I am glad to see the unusual interest shown in Canada in the subject of Medical History. I say unusual because articles on the subject are much more common in Canadian medical publications than they are in our B.M.J. I read with great interest your own articles on the subject, but must confess to an even greater interest in those which deal with the pioneers in Canadian medicine. There is always a risk of these men being forgotten, so that it is good to see their achievements put on record by men who know them. And what a grand record it is!

I am glad to note the increasing attention given to the urgent question of the provision of medical care—a subject of painful interest to us here who are now undergoing an experiment in "mass medicine" which I for one view with great apprehension. I am sure that Dr. Hawley, in the address published in the current Review, is right in saying that the alternatives before the profession in the U.S.A. (and in Canada also) are (1) prepaid insurance provided under the auspices of the profession itself, or (2) nationalized medicine. From my reading of much literature on this subject, coming from the U.S.A., I have great doubts whether the profession will rise to the occasion and provide the public with what I am sure it needs and will demand. I hope my Canadian friends are wide awake on this subject. If not, I prophecy that it won't be long before they find themselves

in the position we are in here, namely that of civil servants at one remove! a position in which it will be easy for any Socialist government to turn it into a body of whole time salaried doctors—no longer a "free profession." However, I must not dwell on this painful and absorbing subject. My object in writing this is to say "thank you" to my confreres in the M.M.A. So long as I live, I shall be a proud and grateful Honorary Member.

Yours faithfully,

Alfred Cox.

Medical Library Keys

At the meeting of the Medical Library Committee, October 31, 1948, it was decided to change the locks on the library's doors by December 1, 1948.

This decision is due to the fact that many of the library's latest and most expensive books have been removed from the library without the borrower leaving any record.

With the large number of keys issued to date, there is a possibility that some may have found their way into the hands of unauthorized persons. Should a doctor wish to **Read** in the library during the evening (7 p.m. to 10 p.m.), Saturday afternoons, or Sundays, a key would be issued to him. The charge of one dollar (\$1.00) will be made for this privilege.

Medical Library Committee.

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Applications are invited for positions as Medical Directors of Local Health Units in Manitoba. Salary range for Physicians with a degree from an approved Medical College and a Diploma in Public Health (or its equivalent) — \$4,500.00 to \$4,980.00 per annum plus expenses, with opportunities for further advancement.

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ARTICLES

The Aims and Objects of the World Health Organization and the World Medical Association

T. C. Routley

C.B.E., M.D., LL.D., F.R.C.P.(C).

General Secretary, Canadian Medical Association;
Chairman of Council, World Medical Association.

During the past two years it has been a very great privilege for your General Secretary to be associated with the organization of two world-wide bodies concerned with the health of the people—all the people on the face of the Globe. While these two organizations are distinctly separate and autonomous they have a common objective which reads, "to assist all mankind to attain the highest possible level of health." It is doubtful if a more completely worthy object has ever been promulgated by an association, or if words more hopeful and significant have found their way into documents dealing with human affairs.

From the physicians' point of view, there is nothing new in this objective unless it be its world-wide application. From ancient times our profession has dedicated itself to the prevention of disease and the alleviation of human suffering. No constitution of any organic union is required to inspire the doctor to continue his ministry of healing; but that which is new in this development is the marshalling of our forces having in view the extension and widening of service to reach mankind everywhere irrespective of race, color or creed or other consideration save one, namely, that he belongs to the brotherhood of man.

To Brazil and China must be given the credit for having suggested at the United Nations Conference in San Francisco, in June, 1945, the establishment within the frame work of the United Nations of an international body concerned with the advancement and protection of the health of the people. Upon acceptance of the proposal, a small preparatory committee, on which Canada was represented by Dr. Brock Chisholm, Deputy Minister of National Health, met in Paris in February, 1946, to examine the proposal, with the result that 62 nations sent 260 delegates and observers to New York in June, 1946, where for more than five weeks they sat together moulding and hammering out the Constitution and By-laws of the World Health Organization.

The Government of Canada was represented at that meeting by the Honourable Brooke Claxton, then Minister of National Health and Welfare;

his Deputy Minister, Dr. Brock Chisholm, and three medical advisers in the persons of Doctors A. Groulx and Charles MacMillan of Montreal, and your General Secretary. One will always remember those days, not for the torrid heat of that blistering New York summer, but for the unique opportunities afforded to become acquainted with many people from many lands, for the friendships which were formed, for the broadening and widening of one's horizon, for the mental stimulation which came from the realization that it is possible for man's humanity to man to cut across language and other difficulties and bind together men and women of good will whose hearts and minds are absorbed in the ministry of healing. That, to me, was the profoundly interesting and hopeful fact which emerged so clearly from the New York conference.

On points of procedure, there were many shades of opinion. In the construction of legal phraseology, there was plenty of argument, but on the main issue of considering the health of all the people of the world, there was unanimity clothed with enthusiastic acceptance of the principle that to every man, woman and child should be given an opportunity to gain and enjoy maximum health. One did not observe any tendencies in the conference to split over ideologies, political considerations, national preferments or territorial gains. On the contrary, there was brought into focus an ideal, an objective, a declaration of good will, which stood out in a troubled world like a beacon light. Yes, the torch was lighted and lifted high but much remains to be accomplished before its radiant light shines throughout the world. Whether or not that light goes out depends upon many factors which lie beyond the influence and control of the medical profession; but our opportunities and responsibilities surely are clear in our own field. We must do all in our power, not only to keep this torch of hopefulness alight but to carry it around the globe in order that mankind may see in this dark and confused world at least one good reason and hope for living together in peace and amity. Service which aims to provide health and healing to all mankind may prove to be the atomic bomb of peace.

Following the New York conference, an interim Commission of 18 persons representing 18 nations, of which Canada was one, was appointed to proceed with the building of the structure of the World Health Organization and to put it in motion. On the invitation of the Honourable Minister of Health for Canada, it was my privilege to sit on the Commission over the next two years, during

An address delivered to the Annual Meeting of the Canadian Medical Association, Manitoba Division, in Winnipeg on October 20th, 1948.

which time upwards of 50 nations expressed their adherence to the organization, thus guaranteeing its position as an integral part of the United Nations machinery. The Commission met five times, once in New York and four times in Geneva. It is a great satisfaction to be able to report that, although the members came from different lands, spoke different tongues and stemmed from different cultures, nothing but harmony and goodwill prevailed at every meeting. The reason for this harmony is not far to see. We were motivated by one objective. We had a task to perform which was challenging and peculiarly unifying, and herein lies the secret of co-operation. If all mankind would only focus their minds upon unselfish service for others, wars would cease because they would have no ferment upon which to rise or breed. Utopian! you say. Yes, probably, but an ideal surely worth working for and one which is certainly more enjoyable than war and less likely to destroy mankind.

By May, 1948, twenty-six nations had ratified the Constitution (the minimum number required to officially constitute the World Health Organization)—and the Interim Commission summoned the General Assembly of the World Health Organization to meet in Geneva on June 24th. 285 delegates and observers from 54 nations, 9 international organizations and 5 military zones of occupation answered the roll call. For a period of one month, working in plenary session and a number of committees, the delegates completed the initial building of the World Health Organization and accepted it as an organization clothed with the necessary powers and authority, and fully competent to embark upon its non-political, humane task of assisting all mankind to attain the highest possible level of health.

A Board of Directors of eighteen persons was appointed to manage the affairs of the organization, with a Canadian, Dr. Brock Chisholm, being elected Director General for a period of five years. Geneva was selected as the permanent site for the head office and arrangements were worked out to establish between five and seven regional offices, strategically placed, around the world. A budget of \$5,000,000 was established for the coming year—(Canada's contribution is approximately \$175,000). Among the projects which were given priority are found the following, showing the amount of money allotted to each one:

Malaria	\$ 235,000
Tuberculosis	270,000
Maternal and Child Health	167,000
Venereal Disease	156,000
Fellowships for Post Graduate	
Study	1,000,000
Publications, Information and	
Library Service	450,000

With respect to the foregoing projects as well as a number of others, it should be underlined that the World Health Organization proposes to act upon receiving invitations and the necessary authority from responsible Governments in whose territories the help of the World Health Organization is desired. It cannot be too strongly emphasized that the World Health Organization is not a superstructure or agency which can in any way interfere with the autonomy of any nation. However, there is already abundant evidence available that the World Health Organization will be invited into many lands — indeed, has already been so invited—to undertake beneficent services in the health field either alone or in co-operation with local authorities.

The foundations of the World Health Organization appear to have been well and truly laid. The superstructure will of necessity grow slowly and manifest its ability to render service as opportunity presents. The organization has a programme and a challenge to fight disease on all fronts, and, in so doing, to help to raise the standards of health throughout the world. There can be no question but that this institution, founded upon the concept of service to all mankind, can be a catalytic agent of universal value.

Concomitantly with the development of the World Health Organization, another equally important international health body was in process of formation. I refer to the World Medical Association.

In the autumn of 1946, on the invitation of the British Medical Association, upwards of 100 delegates and observers from 32 national medical associations met in London to consider the advisability of organizing an international medical association, and it was the privilege of your General Secretary to represent the Canadian Medical Association on that occasion.

Early in the discussions, the question was asked—a question which probably has already occurred to you—why another international medical body? The answer emerged unmistakably clearly. The Doctors of the world, represented by their national medical association, have a common denominator, and have so many problems in common that it appeared logical for them to form themselves into a world body. Furthermore, it was held that, if the World Health Organization is to succeed, it requires the whole-hearted co-operation of the Doctors of the world just as surely as an electric transmission line requires electric power flowing through it in order that it may render service. After several days of discussion, it was unanimously agreed that the World Medical Association should be formed with the following objects:

1. To promote closer ties among the national medical organizations and among the doctors of the world by personal contact and all other means available.

2. To maintain the honour and protect the interests of the medical profession.

3. To study and report on the professional problems which confront the medical profession in the different countries.

4. To organize an exchange of information on matters of interest to the medical profession.

5. To establish relations with, and to present the views of the medical profession to, the World Health Organization, U.N.E.S.C.O., and other appropriate bodies.

6. To assist all peoples of the world to attain the highest possible level of health.

7. To promote world peace.

Time does not permit us to examine closely and in detail all of these objects but I am confident that each of you will recognize in them sound reasons for their acceptance by all medical practitioners who adhere to the principles which have made our calling so great and so noble. There will be recognized, too, similarity in the objectives of the World Health Organization, especially the object which reads, "To assist all peoples of the world to attain the highest possible level of health."

Before the conference adjourned, an Organizing Committee of ten persons was appointed to prepare the Constitution and By-laws and outline the mechanism by which the World Medical Association might function. The Committee met four times during the following year, twice in London and twice in Paris. The first annual meeting was held in Paris in September, 1947, this beautiful city having been chosen primarily because it was the home of the old Association Professionnelle Internationale des Medecins (A.P.I.M.) which was the prologue of the World Medical Association in the years before the war, and enjoyed the support of a number of European nations. To this first annual meeting, 45 national medical associations sent 125 delegates and observers whose main task was to receive the report of the Organizing Committee and complete the writing of the Constitution and By-laws which the committee had prepared. The Canadian Medical Association was represented by Dr. Wallace Wilson of Vancouver, Dr. Leon Gerin-Lajoie of Montreal, Dr. G. D. W. Cameron of Ottawa and Dr. T. C. Routley.

The second annual meeting was held in Geneva in September, 1948. On this occasion the Canadian Medical Association was represented by its President-Elect, Dr. J. F. C. Anderson of Saskatoon, and the General Secretary. Canada had a third delegate in the person of Dr. Anna Wilson

of Winnipeg, who very ably represented the Federation of Medical Women of Canada.

Now, with two annual meetings behind it, the World Medical Association has emerged from the embryonic stage showing every promise of becoming a vitally efficient and useful organization.

The head office has been established in New York City in the beautiful building of the Academy of Medicine of New York, with Dr. Louis H. Bauer in charge as Secretary General. An American Supporting Committee, stemming largely from the American Medical Association and a group of interested business friends, has guaranteed to underwrite the cost of maintaining and operating the central office up to \$50,000 a year for five years. Already, the Committee feels that this sum may be inadequate and has raised its objective to between \$75,000 and \$100,000 a year.

The Constitution provides for an administrative council of ten elected persons with the President, President-Elect and Honorary Treasurer being members ex-officio.

Believing that you might be interested in knowing who the members of Council are and from whence they come, the list is appended hereunder:

Dr. E. Marquis, France (President)

Dr. Charles Hill, England (President-Elect)

Dr. O. Leuch, Switzerland (Honorary-Treasurer)

Dr. Jose A. Bustamante, Cuba

Dr. P. Cibré, France

Dr. Pierre Glorieux, Belgium

Dr. Elmer Henderson, United States of America

Dr. J. A. Pridham, Great Britain

Dr. S. C. Sen, India

Dr. L. G. Tornel, Spain

Dr. John Yui, China

Dr. D. Knutson, Sweden (Vice Chairman)

Dr. T. C. Routley, Canada (Chairman)

Dr. Louis H. Bauer, New York (Secretary-General)

The Association has placed its annual meetings for the next three years as follows:

1949—London, England.

1950—The United States of America (the place to be named by the American Medical Association).

1951—Stockholm, Sweden.

Now, may we turn for a few moments to an examination of some of the activities of the Association. Several surveys have already begun which will bring to light much information which, heretofore, has been unknown because it has never before been gathered together. From the results already available, it is abundantly clear that much of this information will be of value to our own Association and others.

It may come as a surprise to some to learn that the old oath of Hippocrates, so well known to

us in Canada is indeed not well known nor has it been accepted in many parts of the world. It was considered wise, therefore, at the last annual meeting to devise and adopt a new pledge incorporating the principles of behaviour and ethics upon which the traditions and esprit de corps of medicine rests. To Canadian Doctors, its presentation may indicate little, if anything, that is new. But it is very significant to be able to report that this document was accepted by representatives of all the nations who were present, and it was proposed that it be made available in the appropriate languages to all the Doctors of the world. Furthermore, it is believed that its acceptance by the oncoming generations of Doctors in every land will do much to raise the standard of medicine throughout the world. The following is the pledge with which the name of Geneva is to be associated:

At the time of being admitted as a member of the Medical Profession:

(1) I solemnly pledge myself to consecrate my life to the service of humanity.

(2) I will give to my teachers the respect and gratitude which is their due.

(3) I will practise my profession with conscience and dignity.

(4) The health of my patient will be my first consideration.

(5) I will respect the secrets which are confided in me.

(6) I will maintain by all the means in my power, the honour and the noble traditions of the medical profession.

(7) My colleagues will be my brothers.

(8) I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.

(9) I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

(10) I make these promises solemnly, freely and upon my honour.

Considerable time was spent by the General Assembly in discussing the principles of social security, especially those guide-posts around which the medical profession should rally in the interests of both the public and the profession. With this end in view, a declaration of the principles of social security, as affecting the medical profession was adopted and is appended hereunder:

(1) Freedom of choice of physician by the patient.

(2) Freedom of choice of hospital by the patient.

(3) No intervention of third party between physician and patient.

(4) Freedom of physician to choose his location and type of practice.

(5) No restriction of medication or mode of treatment by physician, except in case of abuse.

(6) All medical services to be controlled by physicians.

(7) Appropriate representation of the medical profession in every official body dealing with medical care in Social Security.

(8) That it is not in the public interest that doctors should be full-time salaried servants of government or social security bodies.

(9) Remuneration of medical services ought not to depend directly on the financial condition of the insurance organization.

(10) Any social security or insurance plan must be open to the participation of any licensed physician, and no physician should be compelled to participate if he does not wish to do so.

(11) Freedom of choice of patient by doctor except in cases of emergency or humanitarian considerations.

(12) It is desirable that compulsory insurance be limited to those who cannot pay for their own services.

(13) There should be no exploitation of the profession by anyone.

While there is nothing particularly new for Canadian physicians in this document, again it is important to underline that its acceptance by medical associations throughout the world should do much to protect the relationship of the medical profession to the State and thus demonstrate that the dissemination of information may be helpful to one another.

Medical War Crimes, especially as they were brought to light in post-war Germany, was a subject which engaged the close attention of the Assembly; and the German Medical Association now forming in the Western part of that country, has been requested to repudiate the crimes and medical criminals and give a guarantee against future acts of such barbarity before being accepted as a member of the World Medical Association. If war should ever come again—which we all trust and pray will not happen—it may be that the action of the World Medical Association in this field will act as a brake upon medical war crimes.

Other subjects engaging the attention of the General Assembly were Patent Medicines, Purification of Drugs, Medical Qualifications, Medical Education (under-graduate and post-graduate), Cancer Control, Co-operation with other bodies, Scientific Research, and the ultimate disposition of medical refugees. A number of these problems are being studied by carefully selected committees.

The Assembly decided that the Association should, at regular intervals, issue a bulletin, and, for this purpose, an Editorial Board was appointed consisting of Dr. Morris Fishbein, Editor of the

American Medical Association Journal (Chairman); Dr. Hugh Clegg, Editor of the British Medical Journal; Dr. John Yui, Secretary of the China Medical Association, and Dr. H. E. MacDermot, Editor of the Canadian Medical Association Journal, with power to add. This Bulletin will not be a scientific Journal but rather will be used to acquaint the profession throughout the world with medical problems which normally come before national medical associations. One issue has already been prepared and it is confidently believed that the Bulletin will prove to be an extremely useful medium.

Very briefly and, I fear, somewhat incompletely have I sketched for you the bare outlines of two world-wide organizations through which the medical profession of this and all lands has an opportunity to enlarge its service to humanity. It has been my very great privilege to be intimately associated with the development of these two organizations from their inception to date. As a matter of fact, upon reflection I realize that I am the only person who has had the unique opportunity of following the development of these two bodies from the dream stage to realization; and, indeed, it has been a most satisfying experience to have served on the organization committees of both bodies. And, having had this experience, I think I can speak with some knowledge and assurance when I give it to you as my very firm opinion that the future—the long term future—of the world will be better and brighter because of what has taken place and will take place within the spheres of influence of the World Health Organization and the World Medical Association.

True enough, these are troubled times. One wonders when some incident or accident may touch off a third conflagration which will engulf the world in the worst cataclysm of all time. But, because of fears and doubts and many misgivings, surely it would be blind-folded policy and complete folly to say, "What's the use?" I am sure that we of the medical profession do not entertain any illusions with respect to our ability to make peace or guarantee it. In our normal procedures we have little time for politics or controversies in the political field. We are, to a large degree, occupied in the area of human relationships concerned with health and healing; but, Ladies and Gentlemen, we have many reasons for believing that we can contribute much to world understanding because, as a profession, we have one common objective—the saving of human lives. It may be that, because of our unity of action, the efforts for world peace may be augmented.

The World Health Organization and the World Medical Association were conceived in the hearts and minds of men and women who believe in the

golden rule and place Service before Self, persons whose ambitions were completely unselfish in their expressed desires to do all in their power to provide healing and comfort to mankind everywhere. We in the Canadian Medical Association may be grateful and proud of the opportunity which is ours to play some small part in these two worth-while organizations.

Notes on the World Medical Association

Anna Wilson

On Monday, September 13, 1948, at 1.30 a group who had attended the World Medical Association in Geneva left for London—going through customs in Switzerland and again in England is not as tedious a procedure when there is a merry company. The British bags were bulging with good Swiss cheese, butter, soap and sweets—all allowed—any "spirits" or tobacco had to be secreted carefully as they are disallowed. Duty on watches or cutlery or clothes is extremely high too. The Irish delegate lightened the burden of travel with amusing stories.

We parted at Northolt Airport and proceeded to our homes or hotels to meet again at the British Commonwealth Conference on Wednesday morning at the B.M.A. house in Tavistock Square.

The T.C.A. had arranged a room with bath at Claridges Hotel—a place of former grandeur in the West-end. Small private hotels or ones on the American plan are preferred by this Canadian tourist. However, accommodation is still so short in London, one is glad of any shelter available.

I had scarcely time to change and rush out to the Haymarket Theatre as the performance started at 7.15. Helen Hayes is playing in "The Glass Menagerie" by Tennessee Williams, produced by John Geilgud—It is a rather depressing story which opens in an alley in St. Louis—but the acting is superb.

We had Canadian coffee in a private flat in Cliffords Inn off Feters Lane. From the windows one could see the spires of Lincoln's Inn Library—untouched by bombing, lit by dim lights and a bright moon.

In the morning I wakened to the familiar sound of a telephone bell. Dr. Anderson had called from the Savoy to see if I would accompany him to Whitehall to see the Royal procession arrive for the opening of parliament.

We had a wonderful stand in a doorway at Whitehall where we could see the procession turn in to the street through the Horse Guard's gates. The King and Queen drove to Westminster in Queen Victoria's red Irish Coach with a Sovereign's escort of the Household Cavalry—Welsh Guards in full dress uniform mounted a Guard of Honour.

The colorful uniforms, brass bands and beautiful horses provided bright pictures for Dr. Anderson's battery of cameras. We were blessed by pale London sunshine. Cheering crowds lined the whole route of the drive which lasted about 15 minutes. As the King and Queen reached the Tower a salute of 41 guns began to boom.

The King's speech was the briefest in recent history. The ceremony was over in 4 minutes—so one saw the procession returning as well.

The Duke of Edinburgh in Naval Uniform—and the Duke of Gloucester in Khaki, returned with the Royal procession.

Samuel Johnson said "when a man is tired of London, he is tired of life—for there is in London all that life can afford." We mixed with the cheery London crowd—made for Fleet street and to the small Inn "The Cheshire Cheese" for lunch. Here, in a small room upstairs, we met a young Australian Barrister from Lincoln's Inn Field who wanted to contact Dr. Collins, the Australian delegate to the W.M.A. He gave us his card which we delivered to Dr. and Mrs. Collins from Sydney at the Cafe Royal that night.

The food for which the Cheshire Cheese was famous is a dim shadow of its former substance. Even the beer is thin and the parrot unresponsive. But the Inn, so rich in memories of famous Fleet Street characters, withstood the terrific bombing of that part of London. Near by, in the Inner and Middle Temples the Templar Church and all the landmarks known and loved in that part of London are gone. However, behind the Inn and in Gough Square stands Samuel Johnson's house intact. It is open to public view and one can spend an entertaining hour, admiring original manuscript and pictures of that time which are preserved in this wonderful old house.

The rest of the day we spent in the tower of London viewing with tourist's zeal this fortress, palace, prison—marvelling at the architecture, the exhibits of armour and the crown jewels. We visited the Royal Chapel of St. Peter ad Vincula where Queen Ann Boleyn, Queen Katharine Howard and Lady Jane Grey were buried, after their execution in the Tower Green.

The pilgrimage was terminated by the fact that we were to dine at the Cafe Royal at 7.30 as guests of the British Medical Association. The dinner was to welcome the delegates attending the inaugural meeting of the British Commonwealth Medical Council.

Sir Lionel Whitby, as president of the B.M.A. welcomed the guests. In chatting with him he stated that he knew Winnipeg well through the excellent column of the Manitoba Medical Review. As an honorary member of the M.M.A. he receives the Review regularly. He mentioned especially

Dr. Hossack's medical History section which is read with great interest and cheer.

Sir Lionel Whitby expressed appreciation of the excellent work of Dr. Jan Hoogestratten, a Manitoba grad at present working with him in Cambridge. He said he would be sorry when Jan's cheery and efficient self returned to Winnipeg to work.

I met also Dr. Alfred Cox of Great Britain, who spoke of his wonderful memories of Winnipeg hospitality in 1930—and wished especially to be remembered to Dr. Ross Mitchell—an esteemed friend.

It was a pleasure to renew the friendship of Dr. Janet Aitken of London, who took an able part last year in the International Federation of Medical Women meeting in Amsterdam.

The British are excellent hosts, and all participating agree this was a most enjoyable occasion. Flags of all the Commonwealth countries adorned the tables. Members from all parts of the Empire exchanged friendly greetings in brief, witty speeches. It was a memorable evening.

In the morning of September 15th, 1948, at the B.M.A. House Tavistock Square in London, twenty delegates from Australia, Canada, Ceylon, Eire, Great Britain, India, New Zealand, Pakistan, South Africa and Southern Rhodesia met to consider the formation of a permanent conference of National Medical Associations and units within the Commonwealth.

Dr. Charles Hill, Secretary of the B.M.A., explained that the B.M.A. was making a special effort to improve inter-Dominion professional relationships and it had begun with the creation of the Empire Advisory Bureau as a personal service for Dominion's graduates coming to G.B. for professional or other reasons. It had now invited the National Medical Associations and units within the Commonwealth to consider together the formation of a permanent council or conference.

It was suggested that before considering the formation or structure of a conference or council the meeting discuss the need for some such liaison. There was general agreement that some permanent organization was necessary—and during the discussion the following specific needs were mentioned:

- (1) Social contacts.
- (2) Exchange of lecturers and fellowships.
- (3) Exchange of information on organization and internal administration of National Medical Associations and in developments in medical services, etc.
- (4) Medical Undergraduate education — provision in medical schools of Great Britain for students from all parts of the Commonwealth. Interchange for study of particular subjects—e.g.—

Tropical Medicine.

(5) Post graduate training — more inter-commonwealth opportunities for young practitioners.

(6) Training of medical teachers — suggestion for teams of selected Indian post-graduate students to be appointed to British hospitals with a view to training them as teachers, and fitting them to organize medical schools and colleges in India.

(7) Reciprocity throughout the Commonwealth.

As it was evident there was a general desire and need for some permanent liaison the conference proceeded to discuss the form it should take.

It was decided that it should be kept as informal as possible—no general secretariat or central machinery—and that the delegates should meet in conference. There would thus be no danger of encroaching in the sphere of the World Medical Association.

The Conference took no action to implement these proposals at the meeting but decided its function would be to stimulate individual National Associations into action.

Proposals were drawn up for submission to the associations and units represented. These proposals suggested that in order to develop closer personal and professional relations through National Medical Associates in the Commonwealth an annual conference of Representatives be held.

It was suggested that each country send two representatives to the Conference—which would be held if possible in conjunction with the general meeting of the host association.

It was decided to accept the invitation of the C.M.A. (subject to confirmation) that the first conference of Representatives be held June 7, 8, 9, 1949, in Saskatoon, Canada. Dr. Anderson, Pres. Elect of the C.M.A. would be the president of the first conference.

The holding of conferences in 1950 in Brisbane, Australia, and 1951 in South Africa was considered—subject to approval of association and units represented.

On September 16th, Thursday, there was an informal and enlightening discussion of the new British Health Service. Chairman of Council Dr. Guy Dain (in Sir Lionel Whitby's absence) and the Secretary of the Association answered many questions.

In the afternoon the delegates visited the various departments of B.M.A. House—including the Empire Medical Advisory Bureau, the Public Relations Department, the offices of the British Medical Journal and special Journals, and the Secretarial Department.

Dr. Clegg of the B.M.J., stated he had far more material available than he could ever publish—a happy state for an editor!

It was a thrill for a Winnipegger to visit the

B.M.A. dining hall and see the head of a Western buffalo suspended from the wall. This was presented to the B.M.A. at the memorable meeting in Winnipeg in 1930 when the late Dr. Harvey Smith was president of the Association.

One is impressed by the hospitality of the B.M.A. house, their eagerness to serve Commonwealth visitors and the extent of services they offer so generously. At a cocktail party in the afternoon we met students from all over the Empire, doing post graduate work in London. Here was Dr. Thorlakson also and Mr. Cameron, gynecologist, of Wimpole Street, nephew of our beloved Dr. Neil John McLean.

On Thursday evening a group of the visitors to London attended the supper meeting of the Canadian Club at the Overseas League to hear Beverly Baxter tell in his inimitable style how he became a British M.P.

On Friday the day was filled with visits with friends in London—the Haultons, the Pollocks, Mary Bell of Riverbend fame and the Chowns.—One always eats on these occasions—so we had coffee at Claridges, lunch at Swan's, tea at Green Park Inn, supper at Coquilles in St. Martins Lane. In the evening we saw John Clements and Pauline Letts in "Edward my Son" a popular show at the Lyric. At Bumpus' Book Store I bought James Bone's excellent new book "London Echoing," illustrated by his brother, Muirhead Bone.

Saturday Dr. Anderson and I took a Green Bus to Harpendon to spend the day in the country with Dr. Charles Hill. We visited the Country Fair and drove through miles of beautiful English countryside—then across country to Heath Row Airport to take the T.C.A. plane to Canada at midnight.

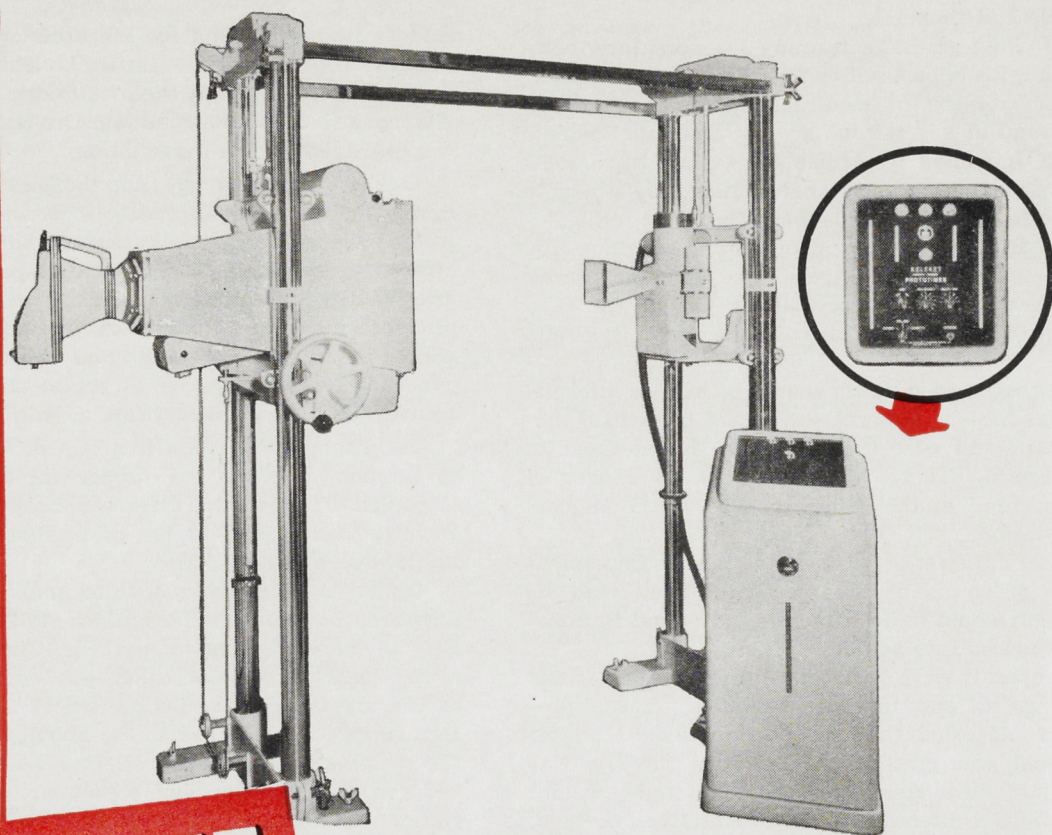
The plane was delayed by storms on the Atlantic so I spent the night at a small T.C.A. Inn nearby. I started off the next morning for a 2-day air journey.

On the tail of Equinoctial gales we were forced to spend 5 hours in a desolate port in Iceland, where only the hospitality of the Icelandic attendants prevented one from wondering how any person survived the cold and scenery. Then after the delay in Sydney, Nova Scotia, we arrived safely at Dorval—and later Winnipeg.

On all these jaunts one is relieved to return to Canada where our way of life and our people maintain a pleasant pattern—remote from thrusts and fears of unpleasant neighbors.

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ASSOCIATION PAGE

Reported by M. T. Macfarland, M.D.

The Annual Meeting, October 19, 20, 21, 1948

Since the date on which the Review goes to press coincided rather closely with the date of the 1948 Annual Meeting, this report is somewhat delayed. The Committee Reports appeared in the November issue, pages 605-625 (odd pages), and references were made in the Editorial and Social Columns of the same issue.

The date for formation of the Association is given as 1908, which means that the convention just concluded is the Forty-First Annual Meeting. The attendance was splendid—a total of 434 members of the Association, guests, visitors and internes being registered. The meeting was later than the western itinerary of the C.M.A. officers and speakers, but the parent body loaned the President, Dr. William Magner, the General Secretary, Dr. T. C. Routley, and the Consultant in Economics, Dr. A. E. Archer. Dr. G. G. Ferguson, Registrar of Saskatchewan Division, was also in attendance. Special speakers were Dr. F. G. Ebaugh, Director of Psychiatry, University of Colorado, Denver, Colorado, and Dr. J. L. McKelvey, Head of the Department of Obstetrics and Gynaecology, University of Minnesota Medical School, Minneapolis, Minnesota. Each of these gentlemen is a recognized authority in his own specialty, and added greatly to the success of the Scientific Session. Appreciation of the Association goes to them and to the several members who also contributed. Dr. P. A. Macdonald, Executive Officer of the Manitoba Cancer Relief and Research Institute may almost be considered one of our own number.

Hospital sessions were held on Tuesday and Thursday morning, while the Scientific Sessions occupied Tuesday afternoon, Wednesday morning and Thursday afternoon. The Business Session was on Wednesday afternoon and evening. Scientific Exhibits were set up in the Windsor Room, and a most successful and representative Commercial Exhibit completely filled the Banquet Hall. The weather was not considered suitable for the Annual Golf Tournament, but several hearty enthusiasts participated on Thursday afternoon.

The luncheon speaker on Tuesday, October 19th, was Dr. Wm. Magner of Toronto, President of the Canadian Medical Association, whose subject was "The National Health Programme." It is likely that Dr. Magner's address will appear first in the C.M.A. Journal. On Wednesday, October 20th, Dr. T. C. Routley, Toronto, General Secretary of the C.M.A., spoke on "The Aims and

Objects of the World Health Organization and the World Medical Association" and his paper appears in this issue.

While the men were hard at work (?) on Tuesday afternoon, the wives of the Executive members were at home to the ladies at a tea which was held in the University Women's Club. Wednesday, Mrs. R. W. Richardson entertained the wives of the Executive Committee members at a luncheon in the Vice Regal Suite at the Royal Alexandra Hotel. Tuesday evening, the President, Dr. R. W. Richardson, provided the usual good food and entertainment for the hard-working members of the Executive, and guests, in the Vice-Regal Suite. The highlight of the social events for members and their wives was the Annual Dinner and Dance, which was held on Thursday evening. A string trio provided light operatic music during the meal, while Cora James and Kerr Wilson entertained with songs. Toasts and speeches were reduced to the absolute minimum—that to "The King" being proposed by the President, and that to "The Ladies" by Dr. W. Gardner, and responded to by Dr. Ellen Douglass. The President-elect, Dr. H. S. Evans, was introduced to the gathering after which dancing to the strains of the Plumm Orchestra was enjoyed in the Crystal Ball Room.

The New President

The Presidency of the Association was passed at the Meeting of the retiring and new Executive Committee, on November 14th, to Dr. Harold Stuart Evans of Brandon, Manitoba.

A graduate in medicine from the University of Manitoba in 1928, and Licentiate of the Medical Council of Canada in the same year, Dr. Evans practised in Timmins, Ontario, before proceeding to Great Britain in 1932, where, the following year, he secured his F.R.C.S. (Edin.). Returning to Ontario, he travelled to far northern parts before settling in Brandon, where he has been a successful practitioner for several years.

A member of fraternal organizations, and ardent sportsman, Dr. Evans has served on the Advisory Commission under the Health Services Act for a three-year term, which was renewed in 1947. He became a member of the Executive Committee of the Association in 1943, and has attended the meetings faithfully and well.

His friends wish him well during his term of office which occurs at a time when significant changes are being brought about in the manner of providing medical care for the whole population.

Clinical Luncheons—December

Listed below are the dates on which Clinical Luncheons would normally be held during the



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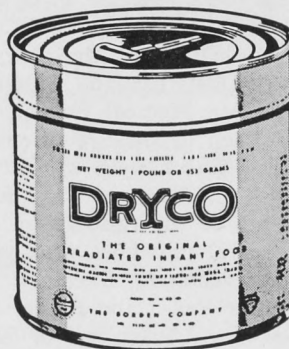
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month of December. Inasmuch as some of these dates may be altered by the Christmas vacation period, members are advised to confirm the information listed with the hospital concerned:

1st Thursday, Dec. 2, Winnipeg General Hospital.

1st Friday, Dec. 3, Children's Hospital.

1st Tuesday, Dec. 7, King Edward Hospital.

2nd Thursday, Dec. 9, St. Boniface Hospital.

2nd Friday, Dec. 10, Victoria Hospital.

2nd Tuesday, Dec. 14, Misericordia Hospital.

3rd Thursday, Dec. 16, Winnipeg General Hospital.

3rd Tuesday, Dec. 21, Grace Hospital.

4th Thursday, Dec. 23, St. Boniface Hospital.

4th Tuesday, Dec. 28, St. Joseph's Hospital.

Tumor Clinics are held at the Winnipeg General Hospital at 9 o'clock each Wednesday morning, and at the St. Boniface Hospital at 10 o'clock each Friday morning.

Ward rounds are held at Children's Hospital each Thursday morning at 11 o'clock, and at King Edward Hospital each Friday morning at 8.30 o'clock.

The regular meeting time of the Winnipeg Medical Society is the third Friday, December 17th. The monthly meeting of Deer Lodge Hospital, Department of Veterans' Affairs, is the evening of the 4th Wednesday, December 22nd.

Southern District Medical Society

A meeting of the Southern District Medical Society was held in the Recreation Room of the Nurses' Residence, Free Mason's Hospital, in Morden, at 2 p.m., on the afternoon of Thursday, September 23rd.

In attendance were Doctors S. S. Toni, President, Altona; J. A. McNeill, Secretary-Treasurer, Gretna; Walter M. Colert and A. F. Menzies, Morden; C. L. Blight, Miami; H. McGavin, Plum Coulee; E. K. Cunningham, Carman; A. W. Andison, J. P. Gemmell and M. T. Macfarland, Winnipeg.

The Scientific Programme consisted of papers by Dr. A. W. Andison, of Winnipeg, who spoke on "Common Difficulties in the Management of Obstetrical Patients," and Dr. J. P. Gemmell, who spoke on "The Management of Diabetes."

A short business session followed, including discussion on Fee Schedule of Workmen's Compensation Board.

Refreshments were served by the hospital staff.

Northwestern District Medical Society

A meeting of the Northwestern District Medical Society was held at Russell, on October 6th. The weatherman did not permit a very large turnout, but those who did manage to "make the port" were well rewarded for their effort.

Dr. F. G. Allison spoke on "Everyday Office Problems," and Dr. C. C. Henneberg gave a review of the latest work on "Pre-eclampsia."

Mrs. T. W. Shaw entertained the ladies during the afternoon and the doctors joined with them

at 6 p.m., for dinner at the Wildwood, a new cabaret on the river bank.

Brandon and District Medical Association

A meeting of the Brandon and District Medical Association was held at Ninette Sanatorium, at 3.00 o'clock on Wednesday, November 10th.

Present were: Doctors A. L. Paine, E. P. Hulke, M. Duggan, E. H. Dobbs, E. Kolesnichenko, Ninette; W. F. Stevenson, Belmont; Richard Roy, Dunrea; J. N. R. Scatliff, Baldur; D. S. Bruce, F. J. Lone, Killarney; I. K. Gilhuly, Minnedosa; F. K. Purdie, Griswold; E. K. Hames, Kenton; J. E. Hudson, Hamiota; B. D. Sutter, Wawanesa; H. E. Helgason, Glenboro; E. J. Skafel, President, J. A. Findlay, E. S. Bolton, S. L. Carey, J. G. Fyfe, W. H. Thorleifson, H. S. Evans, F. J. E. Purdie, Jr., Brandon; Louis Cherniack, A. M. Goodwin, M. T. Macfarland, J. R. Martin, M. B. Perrin, E. L. Ross, D. L. Scott, Winnipeg.

In the absence of Dr. J. B. Baker, Dr. J. A. Findlay acted as Secretary. The minutes of the previous meeting were not available. Dr. I. K. Gilhuly of Minnedosa, was named District Representative to the Executive of the Manitoba Medical Association, replacing Dr. R. P. Cromarty. The scientific programme consisted of three papers—Dr. Louis Cherniack, on the subject of "Physical Examination of the Chest"; Dr. A. M. Goodwin, "Management of the Third Stage of Labor"; Dr. J. G. Fyfe, "Survey of Tuberculosis in Indians Committee to Brandon Sanatorium." During the afternoon the ladies were entertained in the home of Mrs. Paine, where all those attending the meeting were later entertained prior to dinner which was served in the Main Dining-Room.

Following a toast to the King, the President, Dr. J. Skafel, called on Dr. H. S. Evans, President-elect of the Manitoba Medical Association, to say a few words. Dr. Evans spoke briefly on Group Insurance and the Manitoba Medical Service. Each member present stood and announced his name, and Dr. J. R. Martin, assisted by Dr. E. S. Bolton and the "Medical Melodeers," led a hearty sing-song.

Manitoba Medical Service

At the Annual Meeting, a report concerning the activities of the Manitoba Medical Service was given by Dr. T. D. Wheeler. As a result of balloting, five new members will be nominated to the Board of Trustees for a period of three years beginning March 1st. Consideration is also being given to the extension of the coverage offered by this Prepaid Medical Care Plan to groups throughout the Province, and members are asked to give this matter their earnest consideration.

Group Insurance

The report of the Special Committee set up to consider Group Insurance received the approval of the Annual Meeting. This report will be found on Page 617 (Items 44-52) of the November, 1948,

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Inasmuch as 50% of the membership of the Association must be enrolled within 30 days of the date agreed upon by the Company, members are urged to see the representative, Mr. W. Brunning, or reply promptly to any correspondence received in connection with participation in this Group Insurance Plan.

Constitution and By-laws

The proposed revision of the Constitution and By-laws of the Association appeared in the September issue of the Review. Reprints were available at the time of the Annual Meeting and the proposals were ruled Ballot No. 1. The voting was NOT heavy, but the changes were approved unanimously. Instead of marking his ballot Yes or No, one enthusiast wrote "O.K. by me."

Speakers, Canadian Medical Association

Even now the Central Programme Committee charged with preparation of the Scientific Programme for the 80th Annual Meeting of the C.M.A. will be busy arranging the list of speakers. Any members who may have have papers should communicate at once with the General Secretary, Dr. T. C. Routley, 135 St. Clair Avenue West, Toronto 5, Ontario, or with the Executive Secretary of this Division, 604 Medical Arts Bldg., Winnipeg.

Federal Health Grants

Advance notice has been received from the Minister and it has been announced in the local papers on Nov. 20th, that preliminary steps to a thorough study of health care in the province begins next week with a conference opening Tuesday at Ottawa. It will be attended by Hon. Ivan Schultz, Minister of Health and Public Welfare, and Dr. I. M. Cleghorn, Director of Local Health Services.

The meeting, scheduled under the Dominion Government health grant, is to consider the form the survey should take in the various provinces, particularly in regard to health care costs.

The Health Survey grant is for the purpose of a thorough study of all aspects of health care, including medical, dental, nursing and hospital care.

It is expected the meeting will finalize plans for conduct of the survey in Manitoba.

Following Mr. Schultz' return from Ottawa an advisory committee of 15 to 20 persons will be set up for the survey.

The committee will include representatives of the Manitoba Medical Association, the Manitoba Pharmaceutical Association, Manitoba Dental Association, Manitoba Association of Registered Nurses, Municipalities, other organized bodies and the general public.

Claim Forms—Income Tax Deduction

Forms certifying that the claimant was in attendance at the Annual Meeting were available at the Registration Desk. If you failed to get yours,

send your request to the Association office, 604 Medical Arts Building, Winnipeg.

College of Physicians and Surgeons Officers, 1948-49

At the Annual Meeting of the Council of the College of Physicians and Surgeons, held in the Board Room at the Medical College at 9 o'clock a.m. on Wednesday, October 20th, 1948, the following officers were elected: President, Dr. C. B. Stewart; Vice-President, Dr. Edward Johnson; Treasurer, Dr. T. H. Williams; Registrar, Dr. M. T. Macfarland.

The highlights of the meeting and Committee Members will be outlined in these pages beginning next month.

Manitoba Medical Service

The following resolutions, submitted by the Executive Committee to the Board of Trustees of the Manitoba Medical Service, have been ratified by the Board:

Motion: "That claims for service by telephone shall not be accepted as the liability of the Manitoba Medical Service." Carried.

Motion: "That a time limit of four weeks be set for the reconsideration of claims which are declined or reduced by the Manitoba Medical Service." Carried.

Motion: "That where X-ray therapy is used as a substitute for Physiotherapy, the claims for such service be not accepted for payment." Carried.



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SOCIAL NEWS

Reported by K. Borthwick-Leslie, M.D.



Merry Christmas and a Better 1949 - For All



Hearty congratulations to the incoming Slate of Officers for the Manitoba Medical Association. Dr. H. S. Evans (Punk) as President Elect is a natural, if he did look so shy and worried.



Dr. and Mrs. D. F. McIntyre travelled to Toronto to attend the marriage of their daughter, Winnifred Ruth to Robert A. Davis. The wedding took place in Timothy Eaton Memorial Church. The bride, given in marriage by her father, was attended by her sister, Mrs. Carl Malmaeus, Washington, D.C., and Marjorie Lynn McIntyre. Mr. and Mrs. Davies will reside in Toronto.



The Manitoba Federation of Medical Women Executive held their first meeting of the year on Monday, Nov. 1st, 1948, at the Greystone Arms.



Congratulations to Dr. F. T. Cadham on his appointment as Chairman of the Provincial Board of Health, succeeding Dr. E. W. Montgomery, also the other new members—Doctors J. D. Adamson and Ollie Johnson.



Dr. and Mrs. Geo. H. Evoy and Noel must have had a marvellous trip. Four months in Belgium, France, Switzerland, Italy and Britain. They have returned to occupy their new home on Oxford Street. Gosh! George, how do you do it!



After much delay in chasing me around, an interesting letter arrived from Dr. Peter Mar, whose address now is 1054 Fort Street, Victoria, B.C., where he is on leave from St. John's University. Not happy with the far from peaceful outlook in China, he has moved his family back to Canada, hoping to do research work in Biochemistry somewhere. He reports that Roy Mar and Sid Quong are in Hong Kong and both doing well in private practice. Peter is anxious to get in touch with some of our confreres at the Coast, so please let me know the addresses of ones you know of so I can answer him before Xmas—Thank you.

Dr. Kenneth G. Davidson is back home after a year of P.G. work in Chicago and Mayos. He has been certified in Dermatology and Syphilology by the Royal College of Physicians, Canada. Dr. A. M. has trekked to the West Coast so now Ken will have to follow in father's shoes here. Good luck to both of them.



Lots of the boys and girls are becoming important. Matt. Kiernan, now a certified Radiologist, and all those R.C.P.S.C's successful candidates—Ruvyn Lyons, W. J. Friesen, N. P. Merkeley, O. A. Schmidt, E. F. E. Black, R. L. Cooke, E. S. James, G. S. Musgrove—Congratulations all!



The photogenic Dr. Morley Loughheed in Tribune's "Who's Who"—would seem to have made the grade. Quote: "Vital talkative, bristling crew cut and speech," "health missionary," football, bowling, amateur radio operator, returned soldier, cleaner-upper of restaurants, etc.—WOW!



The first general meeting of the Manitoba Branch of the Federation of Medical Women is to be held December 9th, at the Greystone Arms. Dr. Ellen Taylor is to be the Guest Speaker and all lady Medical Students are to be guests of the members.



Born—Robert Francis, second son of Dr. and Mrs. Douglas Hunt, Windermere Avenue, Fort Garry, also to Dr. and Mrs. Ward Shaver, Rossburn, Manitoba, a son on October 30th. Dr. and Mrs. J. E. Rose, Waterloo Street, announce the arrival of their son on November 8th. The boys are certainly in the majority this month. Who will they marry?



Dr. W. I. Easton, Selkirk, Manitoba, reports an excellent meeting and good time at the Interstate Postgraduate Assembly in Cleveland, November 9-12th. He also met Dr. Jake Isaac and G. B. McTavish at the meetings.

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DISEASES	1948		1947		TOTALS	
	Oct. 3 to Oct. 30, '48	Sept. 5 to Oct. 2, '48	Oct. 5 to Nov. 1, '47	Sept. 7 to Oct. 4, '47	Dec. 28, '47 to Oct. 30, '48	Dec. 29, '46 to Nov. 1, '47
Anterior Poliomyelitis	19	44	23	57	118	586
Chickenpox	165	72	123	46	2254	1037
Diphtheria	13	1	2	2	32	71
Diphtheria Carriers	4	1	0	0	9	16
Dysentery—Amoebic	0	0	0	0	0	1
Dysentery—Bacillary	0	1	0	0	11	7
Erysipelas	1	4	2	2	28	37
Encephalitis	0	2	3	11	4	81
Influenza	6	3	3	6	129	155
Measles	71	26	73	62	904	6690
Measles—German	0	0	0	0	34	32
Meningococcal Meningitis	0	2	0	3	13	14
Mumps	131	101	126	29	1632	1351
Ophthalmia Neonatorum	0	0	0	0	0	1
Pneumonia—Lobar	4	3	7	4	131	173
Puerperal Fever	0	0	1	0	1	4
Scarlet Fever	19	14	16	16	194	174
Septic Sore Throat	0	1	0	0	21	14
Smallpox	0	0	0	0	0	0
Tetanus	1	0	0	1	5	5
Trachoma	0	0	0	0	1	2
Tuberculosis	85	56	97	148	1131	1540
Typhoid Fever	0	3	0	2	9	8
Typhoid Paratyphoid	0	0	0	0	2	0
Typhoid Carriers	2	0	0	0	2	1
Undulant Fever	1	0	0	0	12	7
Whooping Cough	11	24	103	81	277	1085
Gonorrhoea	97	120	157	128	1281	1709
Syphilis	34	32	53	43	414	511
Diarrhoea and Enteritis, under 1 yr.	10	12	5	12	148	152

Four-Week Period October 3rd to October 30th, 1948

DISEASES (White Cases Only)	*743,000 Manitoba	*906,000 Saskatchewan	*3,825,000 Ontario	*2,962,000 Minnesota
*Approximate population.				
Anterior Poliomyelitis	19	15	55	300
Chickenpox	165	140	771	---
Diarrhoea and Enteritis	10	---	---	---
Diphtheria	13	---	15	9
Diphtheria Carrier	4	---	---	---
Dysentery—Amoebic	3	---	---	3
Dysentery—Bacillary	1	---	---	3
Erysipelas	1	---	5	---
Influenza	6	---	33	1
Encephalitis	---	1	2	1
Measles	71	92	278	37
Infectious Jaundice	---	---	1	---
Measles, German	---	5	48	---
Meningococcal Meningitis	---	3	6	2
Mumps	131	99	356	---
Pneumonia Lobar	4	---	---	---
Scarlet Fever	19	26	244	102
Septic Sore Throat	---	---	11	---
Tetanus	1	---	---	---
Tuberculosis	85	70	95	325
Typhoid Fever	---	---	3	2
Typhoid Carriers	2	---	---	---
Typhoid Para-Typhoid	---	---	1	---
Undulant Fever	1	2	6	10
Whooping Cough	11	37	54	8
Gonorrhoea	97	---	364	---
Syphilis	34	---	197	---

DEATHS FROM REPORTABLE DISEASES

For Four-Week Period October 6th to November 2nd, 1948

Urban—Cancer, 39; Influenza, 1; Lethargic Encephalitis, 1; Pneumonia Lobar (108, 107, 109), 1; Pneumonia (other forms), 5; Syphilis, 1; Tuberculosis, 8; Diarrhoea and Enteritis, 1; Other diseases of the skin, 1. Other deaths under 1 year, 9. Other deaths over 1 year, 181. Stillbirths, 10. Total, 200.

Rural—Cancer, 31; Pneumonia Lobar (108, 107, 109), 3; Pneumonia (other forms), 3; Tuberculosis, 10; Dysentery, 1; Mycosis, 1; Hodgkin's Disease, 1; Diarrhoea and Enteritis, 3. Other deaths under 1 year, 12. Other deaths over 1 year, 136. Stillbirths, 15. Total, 163.

Indians—Pneumonia (other forms), 5; Tuberculosis, 2; Dysentery, 1. Other deaths under 1 year, 2. Other deaths over 1 year, 3. Stillbirths, 1. Total, 6.



Poliomyelitis. The season for this disease is over and only the odd sporadic or late reported case is appearing in our records.

Breast abscess in mothers and **pustular infection** of infants has been quite troublesome in Winnipeg, St. Boniface and other suburban municipalities. A few cases have also occurred in rural areas. This infection is not notifiable under The Regulations of the Public Health Act but the Department of Health and Public Welfare would be pleased to hear of any outbreaks anywhere in the province. Once started it is difficult to control and requires strict observance of good techniques in maternity wards and nurseries. Most of the cases occur **after** the mother and infant have left hospital. We would appreciate hearing of any similar infections which have occurred when confined at home. Write the Department if you have any information or problems.

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